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TREATMENT OF SMALL STRICTURES.

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[Read before the Medical Club.]

This subject was chosen, not because of any special interest which attaches to it, though the trouble is common enough, and affects a part of our anatomy about which most of us have a deal of solicitude, but because it may promote some discussion, and that I assume to be the object of this custom of paper reading. I may say now in the beginning, that the conclusions I have reached are almost wholly drawn from my own experience and observation, and if I speak with emphasis at times, it is because I have decided opinions grounded upon what I have seen and done. To my subject: There are strictures and strictures, as Moliere says of faggots, but after all only two classes; Muscular or Spasmodic, and Fibrous or Permanent. Now while the urethra is surrounded, throughout its whole extent, by a few muscular fibres, practically it is only in the membranous portion that we find spasm. By membranous portion is meant that part in front of the prostate gland and behind the bulb of the spongy body, or again, that part between the two folds of the triangular ligament. It is here that the constrictor and a part of the accelerator muscles are situated.

Now a spasm may be here produced by a great variety of causes which it is useless to enumerate. This spasm is usually of short duration, though Otis thinks, it may be permanent and even goes so far as to say that deep organic stricture is often simulated by spasm, and the great proportion of such cases are treated for deep stricture which does not exist. Verneuil believes and says that most strictures in the bulbo-membranous portion are spasmodic and owe their existence to a slight fibrous stricture in the anterior portion. He says that in all cases of stricture of the spongy or anterior part, there exists in the membranous portion another stricture which is purely spasm, and which is the cause of the dysuria. I have examined a very large number of strictures with this statement in my mind, and I am prepared to say that I believe it is in the main correct. I take decided issue with Otis, however, when he says that the spasm is likely to be permanent. In my experience, it is decidedly temporary in its character and only appears when the anterior stricture is irritated. So much for spasmodic strictures.

Now, organic strictures result from a deposit of fibrous tissue under and within the mucous membrane of the urethra; they are, of course, permanent and tend to develop. I can believe that a small deposit might be absorbed if unirritated, but practically all organic strictures grow worse. As to locality, all strictures occur in front of the prostate, and, happily, most of them in front of the triangular ligament. The region just in front of the membranous portion seems to be a favorite one, that part under the pubic arch, the sub-pubic curvature, where gonorrhœal inflammation, the one chief cause of stricture, subsides last. In a little less than one-half of all the cases which I have seen the strictures were located in this sub-pubic curvature. I shall say nothing as to the cause, the symptoms, or the diagnosis of the stricture, lest I consume too much of your time, and I shall further confine myself to the subject of tight strictures, or strictures of small calibre, meaning by that, those which will not admit a No. 10 metric scale. Dilatation, by means of steel sounds, introduced at regular intervals undoubtedly tends to promote some absorption of the fibrous deposit in a recent stricture, but it is so slow in its effect and uncertain in its action that whatever merits it may possess in slight strictures it can have no place, I believe, in the treatment of those under consideration. With regard to the reputed value of the electric current in promoting the absorption of these deposits, I purposely shall have very little to say — the whole matter is now under judgment. It is possible that electrolysis may prove a better means of absorbing slight deposits than dilatation, but when the amount of material is large, I have no faith that this method will accomplish its removal in any reasonable time. I say this, too, after having had a considerable experience with it, which experience has not made me at all enthusiastic in its favor, even for slight strictures.

Divulsion was at one time a common method of opening tight strictures; it was claimed, perhaps is now, that the hemorrhage following a lacerated wound of the urethra is not so considerable as that following a cut. Generally speaking, and in most tissues that is true, but in the case of stricture the misfortune is that we cannot limit our tear to to the fibrous tissue, but the healthy membrane, both before and behind the stricture, often suffers more than the stricture itself. I believe divulsion is more often followed by the complications we all dread in these cases than any other operation on the urethra. Whether we regard urethral fever as due to nerve injury alone or septic poison, theoretically, divulsion paves the way for it and practically I have seen more cases of fever and persistent hæmorrhage as its result than follow any other procedure. Most of the cases of urethral abscess that I have met with, in connection with strictures, have been caused by divulsion. For this reason I do not approve of this method of treating strictures, but, on the contrary, I believe they should be cut wide open either internally or from without. We do not, by division, cause any disappearance of the fibrous deposit, but we at once enlarge the canal, and if the wound be kept open a certain length of time the gap is filled in with new granulation tissue. This new material is, without doubt, plastic tissue and in time will, if left alone, contract, as I believe; and so I would not call this, as Otis does, a radical cure; but the main point is, we have opened the canal and it can be kept open indefinitely with a very little trouble. The advantages of division are quick results, the full size of the canal being restored at once; accurate work, in that only the stricture is cut; no more, and as a consequence, and this is borne out practically in my experience, less liability to hemorrhage, fever and abscess. I would cut internally all strictures in front of the membranous part of the canal, and this is a great majority of all strictures which occur, reserving for external section those situated in the deep urethra behind the bulb, including, of course, those which cannot be made to admit an instrument; these must be approached from without, wherever located. I am aware that many surgeons reserve the deep urethra for divulsion, fearing troublesome hemorrhage if internal division is made on account of the extreme vascularity of the part, but if my reasons for discarding the operation of divulsion generally are good, far better are they for refusing it in this locality. It is here that the branches of the internal pudic arteries meet, and a stricture should be divided in the middle line that the loss of blood may be the least. A stricture torn yields at its weakest point which in this case may be upon one side adjoining a large vessel. As the length and depth of the tear cannot be under control, it seems to me the proceeding is one full of danger, and so I condemn it. Another vital objection, which pertains almost equally as well to internal incision in this region, is the impossibility of draining the wound and so keeping it clear; the drainage here is towards the bladder not from it. For these two reasons, then, that we can control bleeding and secure good drainage, I prefer to cut all strictures in the deep urethra from without.

As to the instruments: For internal division, I don't like Civiale's because it does not stretch the stricture and you cannot measure the depth of your cut, nor is it always easy to sheathe your blade after cutting. Maissonneuve's is open to the same objection, that it does not stretch the stricture and cuts backward, which is unsafe. Otis' instrument stretches the stricture, cuts forward, and measures the depth of the cut or size of the canal, but cannot be introduced through so small an opening as Maissonneuve's. This objection must apply to all instruments which cut the stricture from behind, but I consider it a slight one as most anterior strictures can be dilated to allow an Otis instrument to pass. Dr. Rogers, of Memphis, has devised an instrument which forms a bulb after passing the stricture and can, consequently, be introduced through a very small opening, but it makes only a slight incision and this incision can hardly be repeated in the same line, for as the bulb is dilated the instrument tends to revolve on its own axis so that we may have a number of slight incisions in place of one deep one through all the fibrous tissue. I prefer Otis' late instrument with the straight shaft to his former one in which the shaft is curved. Upon first examining a stricture, it is a good plan to introduce into the canal a moderately large sound to definitely locate the trouble, always bearing in mind, if the sound pass the penile portion, the extreme liability to spasm in the membranous part. Having found the obstruction, I endeavor to pass a very small rubber bougie. Failing in this, I dilate the canal with sweet oil injected, and after a few minutes, attempt to introduce a filiform, the canal being kept distended with the oil by closing the meatus with thumb and finger.

Now a word as to filiform bougies: In the interior part I use whalebone, which, by reason of its rigidity, is more easily pushed through a fine opening than a flexible one. The point may be bent or twisted and will retain its shape, which is sometimes of advantage, but its sharp point and stiffness makes it also an extremely dangerous weapon, the engagement of the point in one of the folds or lacunæ of the urethra occurs very easily, and a very small amount of force is needed to pierce the mucous membrane, and you may cause for the patient and yourself an indefinite amount of trouble. False passages are the most vexatious and worrisome complications that annoy the surgeon, and I regard the injudicious use of the whalebone filiform as responsible for nearly all of them. I dislike very much to use them at all in strictures under the pubic arch, for being straight and rigid they will not follow the curve of the urethra, in fact it is difficult to pass them in that region through a sound canal, and I prefer, in their stead, the flexible filiform. To return to our mutton. We were speaking of anterior strictures. If a few minutes careful and gentle trial with the filiform results in failure, I am in the habit of desisting for the present, for strictures vary in their moods, and like a capricious mistress, sometimes they will and sometimes they won't. I have the patient put to bed with an opium suppository in his rectum, and a syringe-full of sweet oil in his urethra, kept there by sealing the meatus. On the day following another attempt is made, immediately after urination, this time with success. If false passages already exist, as a legacy from some over-zealous predecessor, it may be well to leave filiforms in them and attempt to pass another through the stricture, but the presence of the filiform in the false passage often irritates enough to cause spasm, and, practically, I have not derived much benefit from that expedient. I think it better to study the locality of the false passage and endeavor to avoid it. If the filiform runs off into a false passage you will know it by the soft yielding character of the obstruction in front of the point, by the pain caused if no anæsthetic has been used and by the profuse bleeding.

Having passed the stricture, it being an anterior one, if you have used a whalebone filiform you have an excellent guide on which to pass a small tunneled sound and, ordinarily, successive sounds may be pushed over the guide till the stricture is dilated enough to allow the use of the urethrotome. The eyes of these sounds must by very large and have smooth edges that they may glide easily over the whalebone and not cut it. In this part of the penis you may safely use considerable force in pushing the sound over the guide. It is very rare to find an anterior stricture which is permeable and yet will not admit a filiform. I have never seen but one such case. There is very little spasm in that part of the canal and if the opening will let the urine out, it will let the filiform in. The constriction once enlarged to admit the instrument this is passed, preferably upon the guide, beyond the stricture which is cut upon its anterior surface from behind, the fibres being stretched that they may readily yield. Its locality is accurately determined and its distance from the meatus measured off upon the shaft of the instrument beforehand. I prefer to use the guarded blade and to cut and stretch successively till all resisting fibres are divided, the instrument being opened to the normal size of the canal. I think Otis' estimate of what is the normal urethra correct enough for practical purposes. I see no harm in passing a full-sized steel sound into the bladder after withdrawing the instrument to make sure the work is well done. If needed, to allow the full separation of the blades of the instrument, the meatus must be incised. but it is not generally necessary. It stretches somewhat.

Now the wound should be cleansed as thoroughly as possible; persistent irrigation with a bichloride solution till all hemorrhage has ceased, is my plan, the penis allowed to hang low that drainage may be free. The irrigation should be often repeated during the first few days, especially after each act of urination. To guard against chill, it is not a bad plan to give a full dose of quinine just before the operation, and to allay pain afterwards, a suppository of opium and belladonna. Local or general anæsthesia may be necessary during the cutting. Usually the urethra may be made sufficiently insensible with the application of a cocaine solution. Should no complication follow, I pass a full-sized sound on the third day after the cutting. I don't like to wait longer, as the healing of the cut edges must begin at once, and the opening of the cut causes more pain and bleeding the longer it is delayed. After this, a daily introduction of the sound for ten days completes the treatment. Otis, as before said, claims these strictures will not again recur, on the ground that a linear scar will not contract, and cites cases a long while under his observation to prove it. My only comment is, that I have not been so fortunate. I don't believe in the radical cure of tight strictures. The cut is too wide and the amount of scar tissue too considerable. This treatment produces a practical cure, however, the occasional passage of a sound being all that is needed to keep the canal fully open indefinitely.

Now as to deep strictures: After their locality has been determined, and the element of spasm carefully eliminated. I prefer in the place of the whalebone guides to use long flexible bougies tapering down to a filiform point in my first effort to get through, or the same thing, flexible filiforms to which can be attached bougies. Most false passages that I have seen were in this region and as I believe whalebones or small steel sounds were the cause. I cannot too strongly express my condemnation of the use of *small* steel sounds, they have no advantage over the rubber bougies, and are really harmful in most men's hands. The flexible filiform can be made to enter the stricture if anything can, and once within the bladder it should under no circumstances be withdrawn. No one who has been obliged to cut into a stricture without a guide will ever knowingly give up this advantage once gained. To get as thick a guide as possible, you push the filiform as far as it will go through the stricture. Now instead of pushing sounds over this filiform to divulse or dilate the stricture so that Otis' instrument may be used in the canal, I would rather cut down through the perineum and attack the stricture there. It is not possible to drain, and so keep clean, the membranous part of the urethra without an external opening, and there may be a very serious hemorrhage from the deep vessels of the perineum which is very difficult of control in an internal cut. These two objections, which do not exist when a perineal wound is made, are enough to decide me in favor of the latter; practically, also, I have seen less trouble follow external division than internal section, and, as I have before said, far less than follows divulsion. Wheelhouse's sound fills the bill admirably as an instrument to cut against in first getting into the urethra, pushed down to the sub-pubic curve and rigidly held there bulging out slightly the perineum. An incision in the middle line upon the end of this, I think, is easier to cut down than up, and the urethra is spread for about half an inch, the edges of the cut in the canal are then held apart by tenacula or threads, the sound reversed, and the upper end of the slit held by the button. We have now the face of the stricture in view, after bleeding has ceased, with the filiform through it. A fine hollow probe may now, perhaps, be passed alongside or over the filiform to the bladder, announcing its arrival there by a slight flow of urine. A director will usually glide over this through the stricture when both the filiform and fine probe may be taken out. We have now the stricture well in hand and can divide it with the urethrotome or a blunt pointed knife.

As before, I see no harm in now passing a full-sized sound through the whole canal into the bladder, and here is an opportunity for exploring that organ of which advantage may well be taken. After the wound is thoroughly cleansed and the bleeding ceased, a large rubber catheter may or may not be left in the canal or in the wound. As this is apt to cause irritation after a few hours, I think it just as well to dispense with it, unless we wish for any reason to drain the bladder, when, of course, the tube must be left in the perineal wound. If hemorrhage is troublesome and pressure seems desirable, it can readily be made by packing the perineal cut, a catheter being in the urethra, and applying a T bandage tightly. If it has been necessary to open the urethra extensively to get at the stricture, I think it a good plan to stitch it up with cat gut, leaving a half inch at the bottom for drainage. Mastin, I believe, closes the entire perineal wound expecting to get union by adhesion. I have no objection to this if good drainage is provided. If no catheter is left in the bladder I draw off the urine every six or eight hours, at the same time washing the bladder. Some surgeons let the patient make his water freely, more or less of it passing through the cut, claiming that healing is not retarded. I can't agree to that, however, I have sometimes left a soft catheter in the urethra, just through the divided stricture, but not in the bladder, pushing it in the bladder as often as necessary. The cut usually heals in a few days, when the catheter may be discarded, and the only treatment further is the daily passage of a full-sized sound till the stricture is well.

A word as to the impassible strictures: Fortunately they are very rare, I have met with only five in 10 year's hospital experience. I am speaking now of strictures through which the water dribbles, but which you can't enter. It would seem in theory that a passage allowing urine to flow, however slow, must permit some instrument to pass, but the facts do not always support the theory. We must remember the bladder is quite a powerful muscle and by constant effort becomes greatly strengthened; also the dilatation of the urethra behind the stricture has made it more or less funnel-shaped, so that the bladder has rather the advantage of us. Some enthusiast has proposed to forcibly open the anterior mouth of the stricture by water injected through a powerful syringe. I only mention this to ridicule it. Muscular spasm may be largely responsible for its failure; if so, profound anæsthesia will help us; that failing, we must keep open the canal either before or behind the stricture. I choose the incision in front for the reason that there is a fair chance of seeing the opening in the stricture after bleeding is checked and when the urethia is stretched wide open. A Wheelhouse sound is used as before, pushed down to the obstruction, the urethra opened at the end of the sound for half an inch, then reversing the sound and catching up the urethra in the slit, it, the urethra, is further laid open down to the stricture. The perineal wound must be a long one to give plenty of room. Now when the urethra is held apart by threads and all the bleeding has ceased, a good light may reveal to us the point of the stricture. Strong pressure upon the bladder may force a drop or two of urine to ooze through, which will help us out. Gentle probing with a fine hollow probe may discover the channel, or these failing, a careful exploration, with one finger in the rectum and the other in the wound, may disclose the dilatation or bulging of the urethra back of the stricture, this will show us the direction and position of the canal; to make sure an exploring needle may be used. Having now found the canal back of the obstruction, we may open it and attempt to pass a soft probe, bent upon itself, through the stricture from behind, or we may connect these two incisions in as straight a line as possible. In a certain case upon opening the pouch, which I was fortunate enough to find, quite a quantity of gravel gushed out with the urine.

If we have exhausted all our resources and no clue is discovered as to the locality of the urethra, nothing remains but a hunt for it in the mass of cicatricial tissue in the bottom of the wound, and if perineal section, with a guide is one of the simplest operations in surgery, far, very far different is it when you have no guide. You have only the apex of the prostate to aim for and to try and keep in the middle line, which is just about as easy as walking a slack rope. With your finger in the rectum its tip against the prostate, repeated short incisions through the cicatrix *may* reach the urethra, or it may be that the cicatrix must be dissected out *en masse*. Some surgeons advise that this be done anyhow, after you have divided the stricture. The wound being a large one may well be closed, except the lower part, and the after-treatment managed as before, and it goes without saying, that throughout the whole time scrupulous attention to cleanliness must be shown.

It is, perhaps, here not inopportune to say a word about retention of urine, when caused by and complicating stricture, and its immediate treatment. It often happens that an old fibrous stricture, which has formerly given but little trouble, suddenly closes, as the result of exposure to cold, alcoholic excess or other cause; spasmodic, of course, and only occurring in the region of the cut-off muscle, the membranous part. Under the circumstances, the patient's suffering soon becomes intense and relief must be obtained. It is my habit, in these cases, first to expand the urethra with as large a steel sound, well warmed, as will enter the meatus, pushed down to the face of the stricture, holding it there a few moments. I then attempt to pass a very small gum elastic catheter into the bladder. If successful, I leave this in for several hours allowing the urine to dribble away continuously. If unsuccessful, I give the patient a suppository of opium and belladonna, and place him at once in a hot bath, raising the temperature of the water all he will allow. After 15 minutes, I let him attempt to pass his water in the bath. Not succeeding this time, I have him anæsthetized and again endeavor to get an instrument in the bladder, this time a filiform, which, if it enters, serves as a guide for a small tunneled catheter. If nothing can be made to pass the obstruction, the question of operation comes up. As the spasm is usually due to a temporary cause, it is fair to presume, and the presumption is borne out in fact, that it will soon cease, the cause disappearing, and we have but to provide for the escape of urine for a short time. However, if the situation has already lost many hours, there is a strong probability that the urethra behind the stricture has been injured, though, fortunately, the prostatic urethra is the strongest part of course. The condition of the perineum, then, is a good guide for our conduct. A man having suffered many hours with a distended bladder is not in good condition for a prolonged operation, and, I think, the bladder can best be relieved by aspiration, unless there are positive evidences in the perineum of urinary infiltration or abscess, in which case, perineal section should be made at once. Aspiration is quite free from danger and may be repeated many times till the urethra is opened in one way or another. Taking advantage of the fact that the bladder is more readily emptied at the same time with the rectum, I have given a dose of croton oil to the patient while in the bath, with good effect. As to drugs, I have no faith in any save opium, but I find in it a two edged sword, which while allaying spasm at the same time paralyses the bladder, thereby making the use of the catheter necessary.

REMARKS ON TYPHOID FEVER.

By William S. Ely, M. D., Rochester, N. Y.

[Read before the "Central New York Medical Association" at Rochester, N. Y., Nov. 20, 1888.]

Mr. President, and Gentlemen: — The prevalence of typhoid fever this autumn, to an unusual extent, may justify calling your attention to what may be considered a well-worn subject.

Though the disease is one that many people believe should be stamped out with the increasing efficiency of State, Municipal, and Town Boards of Health, its control has not kept pace with sanitary progress. The reason for this is not far to seek. We are still ignorant of much that relates to the causation of typhoid fever. It is well to understand that defective drainage, unfavorable conditions of ground soil, bad water and impure milk, which are often considered adequate for the production of the disorder in question, must be deemed simply as favorable influences for the development and spread of the specific germ which we now regard as its essential cause. This germ was first isolated in 1871, by Recklinghausen. Subsequently, it was exactly described by Eberth and Klebs, and was classified by them among the group of bacteria called schizomycetes. But its life history is still wrapped in mystery, and the conditions governing its rise and spread, are yet to be determined. There is thus opened up to the diligent student a fruitful field for further research, and a professional reputation is to be made in the discovery of the missing data which have reference to the obscure questions surrounding the typhoid germ.

Perhaps the furthest point yet reached in this investigation, is the discovery of the typhoid bacillus in the blood, taken from the incisions made in the rose spots of typhoid fever. In nine out of 15 cases examined, the germ was found. Though the disease has been long known, and is widespread, its diagnosis is often perplexing. Nearly always doubtful at first, it is at times obscure throughout. Occasionally it happens that the diagnosis has only been settled by a post-mortem examination. While well-marked cases are easily diagnosticated, there are those which baffle recognition except by the most experienced.

I have often thought that typhoid fever was one of the disorders which might be compared to the dissected map of the nursery. Though the picture was easily recognized when all of the pieces of the map were present and properly placed, the solution became difficult in proportion as essential parts were lacking. It might be said that he was the most skilful diagnostician who could construct the map or picture of typhoid fever from the smallest number of blocks. Few cases answer to the descriptions of the text books. If we consult leading works on Practice, and then stand at the bedside of the patient, the two pictures do not agree. This is often perplexing to the young practitioner, and some experience is necessary before he finds an explanation of the apparent contradiction. The fact is that text books give necessarily what may be called composite pictures of disease, and do not describe the particular case which we see, which was never, in fact, seen by their author, for nothing in nature is ever exactly duplicated. Hence, principles only are gained from standard authorities. General likenesses only are furnished, from which we must expect wide variations.

While it is ordinarily stated that typhoid fever is a disease of three or four weeks, careful observations in this latitude show that the fever in many cases lasts five, six, seven, and possibly eight weeks. The diagnosis will be aided if we bear in mind that the disease must be considered a species of which there are many varieties. We see cases marked by wide fluctuations of temperature; or by an excess of delirium and nervous symptoms; or by an unusual tendency to hemorrhages; or by a susceptibility to relapses; or troublesome gastric and abdominal eruptions; or by disproportionate pulmonary eruptions; or by malignancy, blood disorganization, and tendency to early death; or by troublesome sequelæ, as neuritis, atrophies, paralysis, etc., or finally by combinations of the above variations. Hence, there is furnished abundant material for obscurity of diagnosis. The more common errors are made in considering typhoid fever as a malarial disorder, of remittent or intemittent type; or in confounding the affection with acute pulmonary tuberculosis, or with tubercular meningitis of children.

Under such confusing conditions, long experience, not only with typhoid fever, but with the disorders with which it might be confounded, will often be required to reach a correct judgment. The information derived from a single visit to a patient, and a single observation daily at the time of the visit, may be inadequate for the perfect comprehension of the condition we have to treat. From four to six daily observations of pulse, temperature, and respiration, with the most careful clinical record, detailing every symptom, will frequently aid in clearing up doubtful cases; for the diagnosis represents really the exercise of the best judgment of associated symptoms, no one of which can be deemed pathognomonic. And often with this careful watching and full record, days must elapse before we can be certain of the nature of the trouble.

In every case of continued fever, where visceral lesions adequate to account for the disturbance can be excluded, the suspicion of the existence of typhoid fever should be entertained, and the patient should be treated accordingly.

It will thus be inferred that there are few typical cases of typhoid fever, and that atypical cases are the rule. The lineal temperature curve of the text books will seldom be seen. We are to expect variations, and if they are not found, it is because our observation has not been sufficiently close. Then, too, in the opinion of those longest in practice, a change of type has been noticed in the disease in various parts of the world. Since the early descriptions of Chomel and Louis in France, typhoid fever has undergone marked changes in its manifestations, and even in this country the experience of the oldest physicians leads to the impression that whereas it was formerly often sthenic in character, it has now become an asthenic disease.

With reference to the medical treatment of typhoid fever, I do not propose to say much. Many can remember the extent to which the treatment was formerly symtomatic, in the sense that medicine was given for nearly every symptom.

Patients took remedies for the dry tongue; for the cough; for the vomiting; for the diarrhœa; for the tympanites; for the delirium; and but little attention was then paid to diet, ventilation, and disinfection. It was not then known that the disorder represented the reaction of the system to a specific poison, a true "contagium vivum," having a more or less definite life history, marked by a period of incubation and invasion, with an eruption, not only on the trunk, but, if you please, on that modified skin of the intestines, known as the mucous membrane. We thus see an analogy not altogether fanciful to the class of eruptive fevers, and are led to the inference that whatever the future may have in store for arresting or aborting the disease, we have at present no specific for it. The old minister who, many years ago, refused to take any remedies when suffering from typhoid fever, affirming that the disease was the best medicine for him, was in advance of his time, and may have been wiser than his physician.

Let us then remember that we have to deal with a disturbance which must last weeks, in which incendiary medication may be dangerous, and the most careful measures will be necessary to conserve the strength of the patient. We can cure the disease only in the original signification of the word, to care for it. Greater dependence is therefore to be placed on nursing, air, water, diet, and quiet, and the more these influences are employed the more adequate they will prove in the treatment of ordinary cases.

Milk will be found, as a rule, the main food, in some form or combination. It may be given cold or hot, or as Koumyss. Lime water will often aid its retention. In my own experience, milk is better borne by typhoid fever patients than any other one article. The whites of from three to 20 eggs a day can, at discretion, be incorporated with it. If the bowels are confined, animal broths may be substituted for the milk, and an enema given, if necessary. Over and over again it has been demonstrated that broths act as a laxative in disorders where the tendency is to diarrhœa. Digitalis is often serviceable as a heart tonic and regulator. In very asthenic cases strychina may be given hypodermically, or by the stomach, in small doses over periods of days, with favorable effect. It is a good rule to defer the administration of stimulants as long as possible, and then to begin with milder forms, as sherry in limited amounts, gradually increased, and later displaced by whisky or brandy if necessary. At times the system will tolerate one form of stimulant better than another. Very little medicine is given regularly. One drop doses of carbolic acid and tincture of iodine three times a day represent as harmless a treatment as can probably be employed. Great virtue has been attached to this combination, on the theory of its antiseptic action on the stomach and intestines. Though this view may not be sound, the prescription is frequently used. Quinine or salicin will often act well in small doses as a tonic. Diarrhœa should be controlled, but not entirely arrested. For intestinal hemorrhage, ice upon the abdomen, and ergot and opium internally, are the common practice, and represent probably as good a treatment as we now possess. Surgical interference has been advised for intestinal perforation, but the results have not been encouraging. Although four deaths have followed this operation in four cases, I hardly think that it should be condemned and entirely abandoned, when, without interference, a fatal result seems inevitable in every instance.

It is interesting to observe the different views which have been held as to the effect of high temperature in typhoïd fever. There has been a gradual modification of the idea that high temperature was always and necessarily alarming, and to be controlled by all possible measures. By some physicians it is now deemed nature's way of destroying the bacteria, and thus contributing to the cure of the disease. The truth probably lies between the two opinions. My own impression has been that a temperature above 103° over a long period was exhausting, and rapidly destructive of nervous tissue; and that where this temperature could be controlled by simple measures, as tepid sponging, or moderate doses of quinine, or antipyrin or antifebrin, the use of these agents constituted good practice. In many cases alcohol will lower the temperature, though as yet, we can never say in advance that this will be the result. Its use is therefor for this purpose experimental, and its continuance or abandonment must be governed by its effect. It will thus be inferred that very much of the success that will be reached in the treatment of typhoid fever depends upon its care, and this means its nursing. There is no disease in which a competent and judicious trained nurse can be more serviceable. If she represents the highest evolution of the nurse, she will make the physician feel that he has visited the patient many times during the day and night, whereas he may have made but a single visit, because she is able to picture the case to him from hour to hour, and to record the pulse, temperature and respiration, and all the varying symptoms of the disease vividly and accurately. This, in short, is the test of a good clinical record furnished by the nurse, that it gives most of the information which the physician would obtain if present.

The view entertained by many physicians that in continued fevers the stomach must have stated periods of rest by night or day, has been proven, in my experience, without foundation. On the contrary, the stomach can be made to work all of the time without distress or embarrassment. Patients can be fed small quantities of food every hour, or in exceptional cases oftener, with good effect. I have in mind one patient with typhoid fever, who was fed 96 times a day for several days, without difficulty. This unusual frequency of administering nourishment was made necessary by the irritability of the stomach, which would permit of half an ounce of food being taken every 15 minutes, whereas an ounce every 30 minutes, or two ounces every hour, would invariably be rejected.

No absolute rule can be laid down upon this point. Each patient seems to be a law unto himself, as to his stomach tolerance or intolerance, and the judgment of the physician will be taxed to determine that system of feeding which will supply to the patient the necessary amount of nourishment with the least inconvenience.

The most trying period in the management of the typhoid fever patient is often associated with his convalescence. Weak as he may be, he is frequently much stronger than his medical attendant, and from the lack of firmness of the latter, the patient suffers from eating or exercising improperly, or from being subjected to injurious influences. We have to recollect that after the fever is ended the mucous membrane of the stomach and bowels is still in a state of softening, the spleen is still enlarged, and every microscopical cell in the body must undergo molecular reconstruction.

The patient's appetite and desires are seldom a safe guide in determining what may be eaten, or drank, or done, with impunity. This was forcibly impressed upon me many years ago, in a case of a patient who had gone safely through the febrile stage of the disease, and then craved solid food in large amount, and was gratified by a meal of beefsteak. An acute inflammation of the stomach and bowels ensued, which ended fatally in a few days. Such an experience has, ever since operated to make me extremely careful for the first two or three weeks of convalescence.

ADENOMA OF THE MALE BREAST.

BY ROSWELL PARK, M. D.

A young man of 17, living at Boston, Erie Co., was brought to me by Dr. Strong, in November, 1887. His history was that two and a half years ago, he received a blow on the left breast from a plow handle; that soon after this a nodule appeared there as large as a common marble. This remained stationary for a while, and then slowly enlarged; until summer of 1887 he was in good health; since then, he has complained of great pain, especially on moving the left arm. His principal complaint was of soreness and pain, and he carried his body in such a way as to avoid friction of his clothing, even going so far as to walk with a species of limp.

There was evident enlargement of part of the mammary gland, and as certainly the parts adjoining were in a very irritable, hyperæsthetic condition. The nipple was not enlarged, nor its appearance altered. The tumor was quite movable over the thoracic wall and beneath the overlying skin. The mass was in its largest diameter about six centimetres, and its thickness was two centimetres. The axillary glands were not affected, nor were the supra-clavicular.

November 30th, in the surgical clinic at the General Hospital, under ether, I excised the mass, making an elliptical incision, and removing the nipple with the tumor. It was easily dissected from the underlying pectoral fascia. It had all of the physical characteristics of an adenomatous enlargment of the rudimentary mammary gland. The wound was closed by catgut, without drainage, and was completely healed within five days.

The patient's recovery was complicated by a sharp attack of measles to which he had been exposed shortly before coming to the hospital. On microscopocal examination, the tumor was found to consist of a pure type of adenoma which would have been perfectly physiological in the female approaching puberty. Subsequent reports from the young man show him to be completely relieved.

MEDICAL APHORISMS.—A correspondent, signing himself "Artz," sends to the *Canada Lancet* the following professional aphorisms of Amedee Latour:

(1.) Life is short, patients fastidious, and the brethren deceptive. (2.) Practice is a field of which tact is the manure. (3.) Patients are comparable to flannel—neither can be quitted without danger. (4.) The physician who absents himself runs the same risk as the lover who leaves his mistress—he is pretty sure to find himself supplanted. (5.) Would you rid yourself of a tiresome patient, present your bill. (6.) The patient who pays for his attention is but exacting; he who does not is a despot. (7.) The physician who depends on the gratitude of his patient for his fee is like the traveler who waited on the bank of a river until it finished flowing, so that he might cross to the other side. (8.) Modesty, simplicity, truthfulness! —cleansing virtues, everywhere but at the bedside; there simplicity is construed as *hesitation*, modesty as *want of confidence*, truth as *impoliteness*. (9.) To keep within the limits of a dignified assurance without falling into the ridiculous vauntings of the boaster constitutes the supreme talent of the physician. (10.) Remember always to appear to be doing something—above all, when you are doing nothing. (11.) With equal, and even inferior talent, the cleanly and genteely dressed physician has a greater advantage over the untidy one.—*Independent Practitioner.*

A COLLAPSED DRUGGIST.—"I want some consecrated lye," he slowly announced, as he entered the store.

"You mean concentrated lye," suggested the druggist, as he suppressed a smile.

"Well, maybe I do. It does nutmeg any difference. It's what I camphor, anyhow. What does it sulphur?"

"Eighteen cents a can."

"Then you can give me a can."

"I never cinnamon who thought himself so witty as you do," said the druggist, in a gingerly manner, feeling called upon to do a little punning himself.

"Well, that's not bad, ether," replied the customer, with a syruptitious glance. "I ammonia a novice at the business, though I've soda good many puns that other punsters reaped the credit of. However, I don't care a copperas far as I am concerned, though they ought to be handled without cloves till they wouldn't know what was the madder with them. Perhaps I shouldn't myrrh-myrrh. We had a pleasant time, and I shall caraway—"

It was too much for the druggist. He collapsed.—*Detroit Free Press.*

ACTION OF BITTERS.—From recent experiments Prof. Botkin (*L'Union Medicale du Canada*) asserts that,

1. Bitters diminish the digestive power and retard digestion; they diminish the quantity of peptones.

2. Bitters diminish the secretion of the gastric juice. If they produce a feeling of hunger, it is only by irritating the gastric mucous membrane.

3. Bitters have no influence upon the secretion of the pancreatic juice or the bile.

4. Bitters not only do not diminish, but actually promote fermemtation in the contents of the stomach.

From all this, the author is led to believe, contrary to current medical views, that bitters are of no use in the treatment of disorders of digestion.—*Dietetic Gazette.*

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VOLUME IV.

The year 1889 opens auspiciously for THE MEDICAL PRESS OF WESTERN NEW YORK. Its third volume will show by comparison with its predecessors that the standard of increasing excellence has been maintained. If the kind words of its friends and the respect of its critics count for anything, its conductors have kept their promises and have redeemed local medical journalism from the discreditable character attached to it prior to the appearance of THE PRESS.

With the volume to follow, the efforts of its conductors shall show increased efforts in behalf of its readers. An increase in the number of its pages, and the use in many places, of a compacter type will permit the addition of much that will enhance both the size and the interest of the journal.

It is intended to pay particular attention to the editorial department of the succeeding numbers. To this end the names of Drs. Chas. G. Stockton and J. H. Pryor have been added to the editorial staff, and our readers may therefor confidently expect the pleasure of perusing frequent articles from the pens of these talented writers and gifted teachers.

The editor invites, always, the communication of interesting cases and correspondence concerning matters of scientific interest. Not the least interesting of its attractions, in the past, have been the letters from abroad. Endeavor will be made to continue this feature, as well as to add to its other items of interest.

Subscribers and advertisers will please communicate directly with the Lakeside Publishing Company concerning all matters pertaining to the business of the journal.

THE REMOVAL OF THE UTERUS FOR CANCER.

At the last International Medical Congress, the operation of Vaginal Hysterectomy attracted much attention and, since that time, has been performed with increasing frequency in this country.

Although extirpation of the uterus had been occasionally performed before, it was not until 1878 that a well-considered plan was proposed and tried. This was done by W. A. Freund, in Germany. His method was to open the abdomen from above, tie the broad ligaments and remove the uterus. He found numerous followers, and in 1881, 93 cases had been reported with a mortality of 63. These results were so bad that Freund's operation has been virtually condemned. Czerny, of Heidelberg, was the first to remove the uterus through the vagina, without the abdominal incision. His methods have been greatly improved upon by later operators in Germany, France and the United States.

At first the operation met with great opposition in some quarters. It was urged that the mortality was so great that it was entirely unjustifiable, being little more than legalized murder. With improvements in technique and consequent improvement in results, these objections, as was the case with ovariotomy, died out and vaginal hysterectomy stands to-day an accepted operation.

Although accepted, there are still differences in regard to details. Some operators tie the broad ligaments beginning either at the top, by retroverting the fundus through an opening into Douglas' cul-de-sac, and thus bringing it almost outside the body, or they accomplish the same thing by tying the vaginal attachments first, and the broad ligaments later ; while others prefer to use clamps, thus effectually and quickly controlling the hemorrhage. Having tried both methods an equal number of times, we must give our verdict in favor of the clamps. They facilitate the operation very greatly, having enabled one operator to remove the diseased organ in less than 15 minutes. They do way with almost all danger of hemorrhage and maintain an open channel for drainage. The clamps are left in place from 36 to 48 hours.

Even with simplification the operation is far from being an easy one. Most of the operating is done in the dark, by the sense of touch alone, and it requires both skill and experience to perform it quickly and well. There is, however, great difficulty in any operator getting his experience unless he be placed in exceptional circumstances. This is not owing to any lack of cases of cancer of the uterus. Alas ! they are alarmingly common, but rather to a lack of proper cases or cases in the right stage. Cancer is one of the most insidious of diseases. Often it has made most astonishing progress before its presence is even suspected. A slight vaginal discharge with a feeling of pelvic discomfort may be the only symptoms, even after the disease has lasted for months. This being so, few women present themselves for examination in time. In other cases the family physician is sometimes to blame. It is not unusual to see cases where the attendant has persued an expectant plan without making an examination and a diagnosis long after the symptoms should have aroused his suspicion and led him to such a course. One reason for this is that both in the minds of the profession and of the laity there is an idea strongly prevailing that unless there is severe pain there can be no cancer. Never was there a greater mistake.* Many and many a mistake goes through to a fatal termination without an instant's suffering. While in cases where pain is prominent it is usualy only in the later stages.

Another point that should be borne in mind is that in women past the menopause, any vaginal discharge, especially if it be watery and bloody, should excite suspicion and lead to a careful vaginal exploration ; not a specular examination necessarily but a thorough exploration of the pelvis by the finger. If these points were kept in mind, more cases would be seen in time and consequently our operators would be able to gain greater skill and get better results than now. We may at present in the hands of good operators expect from 80 to 90 per cent. of recoveries ; some having done even better than that.

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* See Vol. I., No. 1, MEDICAL PRESS OF WESTERN NEW YORK.

A more important question is: What percentage of permanent cures may be expected? The same question is applicable to any operation for the removal of a cancerous organ. In answering it we must first decide on what is meant by a permanent cure. Some have decided on four years as the period which must elapse without return of the disease before a cure can be safely announced.

Unfortunately the operation is too new to admit of a satisfactory answer being given. We must wait for more time and more cases. So far the results are not very encouraging, and seem to show that total extirpation in a great majority of cases only puts off the evil day. But granting this, if in a considerable series of cases the totality of life, lived by the patients operated upon, is greater than a similar number seen at the same stage of the disease and not operated upon, the decision must be in favor of the operation. As regards the merits of this operation over its rival, high amputation, we must be content to wait.

Nothing is to be gained by operating on cases not fitted for operation. It should be a cardinal rule never to operate after the uterus has become fixed in the pelvis or any of the surrounding tissues are involved. It is sometimes impossible to tell when this has taken place, but usually it is easily discernable to the examining finger. Unless this rule is observed, the mortality will be very great and recurrence rapid, and undeserved discredit thrown upon the operation.

THE PROPER MANAGEMENT OF CONSUPTIVES IN VIEW OF THE POSSIBLE CONTAGIOUSNESS OF TUBERCULOSIS.

The man who believes what he says is convincing; and Dr. Flick, of Philadelphia, in a recent paper on "The Contagiousness of Phthisis,"* not only demonstrates his own faith, but presents it in so earnest and masterful a manner that he is likely to carry with him to the conclusion that consumption, like typhoid fever and cholera, is contagious, many who have hitherto accepted the notion in a much more limited sense.

Dr. Flick develops the theory by marshalling those facts which usually are employed in support of the dogma of infection.

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*Transactions of the Medical Society of the State of Pennsylvania, 1838.

He shows how English colonization has spread the disease to regions previously exempt; how it first appeared among the American Indians, after the advent of Anglo-Saxons, on the Atlantic sea board, and then found its way with the march of imigration to the red man of the West. He shows how this, like other infectious diseases, is less active in localities where it has long prevailed, and is extremely virulent when it appears in new territories.

Without attempting to discuss the interesting question of what influence this may have on race development, he describes how inhabitants of America, Africa, and the islands of the sea have perished of tuberculosis and have disappeared before the infecting British.

After citing numerous other pertinent circumstances, Dr. Flick proceeds to prove that phthisis has a predilection for certain localities wherein persons are most exposed; and, having examined the Brompton Hospital statistics, discovers, by the praiseworthy method of systematic investigation, that, in the fifth ward of Philadelphia, for the past 25 years, the disease has found its victims most in certain localities, in a measure parallel to that of typhoid fever and similar affections.

Reference is made to the practice of isolation and disinfection carried out in Southern Europe, to the good therefrom resulting, and he closes with an inspiring plea for governmental interference for the protection of the people and the destruction of the plague.

This brings us to the management of the phthisical provided the doctrine, above described, be accepted.

It would seem that the rational colonization of its subjects would be be a sensible way of dealing with consumption. Such a plan has been suggested to us in a letter recently received from Dr. J. H. Sloan, of SanteFe, N. M. Although we have no further knowledge of the gentleman, his suggestion is worthy of careful examination, at least. The idea, briefly stated, is based upon the belief that consumptives do best when enjoying a "tent life" in the woods and mountains of a dry temperate climate having a high altitude; that they require society, recreation, amusement and competent medical supervision; that they should be provided with the accommodations of a suitable sanitarium, in the same region, during the few short winter months; and all this he offers to provide for a consideration.

Now when the investigations and conclusions of Dr. Flick are placed beside the proposals of Dr. Sloan, it does seem as though the pathway of the unfortunate consumptive was made a little easier, as though our duty to him was made a little clearer.

ADMINISTRATION OF CODLIVER OIL AND CASTOR OIL IN PALATABLE FORMS.

The great therapeutic value of codliver oil in phthisis, scrofulosis, and similar disorders, is recognized by all physicians, but its administration is often prevented by its markedly disagreeable odor and taste, which frequently produce nausea, and sometimes actual vomiting in those who attempt to take it.

One of the problems of modern pharmacy has been to produce a palatable preparation of codliver oil. As a result, there have been placed upon the market a large number of patented or proprietary emulsions of the oil. All of these preparations are advertised more or less as cures for consumption and other wasting diseases. Some have a general formula stating that the preparation contains a certain percentage of codliver oil made into emulsion and combined with one or more articles of doubtful therapeutic value. Others have an exact formula published with the preparation. The latter are a trifle more worthy of recommendation than the former, but all bear the stigma of being patented or proprietary articles, and, therefore, should not be prescribed by a physician if he knows any other method of prescribing which will produce a palatable and useful preparation of codliver oil. The object of these remarks is to introduce to the profession a formula which meets those requirements. It was originated by the writer when *interne* in the Buffalo General Hospital in 1883. It is as follows :

Ol. Morrhuæ,	℥viii.
Aquæ,	℥ivss.
Sodii Carb. Exsiccat,	gr. x.
Ol. Eucalypti,	ʒi.
Spt. Frumenti, q. s. ad.	℥xv.

Dissolve the Sodii Carb. Exsiccat (the Bicarb must *not* be used) in the water, add the oils and the whisky, and mix well by violent shaking. As this contains 53⅓ per cent. of codliver oil by volume, the dose can be calculated on this basis. The oil of Eucalyptus covers the taste of the codliver oil better than anything else that we have been able to find, but as its own taste is disagreeable to some patients it can be replaced by the oil of wintergreen, the objection to this being that the taste keeps coming up into the mouth for some time after taking the dose.

That this is a true emulsion can be learned by the microscope, the evenness and firmness of the emulsion depending upon the amount of time and energy used in the original mixing. For a proper emulsification the ingredients should be poured into a pint bottle and shaken *violently* for from three to five minutes. Before each dose the bottle should be again thoroughly shaken for about half a minute. The 15 ounce mixture is made in order that there may be room in the pint bottle for the violent agitation that is necessary at the first mixing.

Another excellent formula is one of Prof. Chas. G. Stockton's. It unfortunately, however, has as one of its ingredients a proprietary article, viz., Rose's Peptonized Beef. The formula is as follows:

Rose's Peptonized Beef,	℥iv.
Sacch. Albi,	℥ii.
Ol. Gaultheriæ,	m. xxv.
Ol. Morrhuæ, (Squibb's)	℥viii.
Alcohol,	℥i.
Aqua q. s. ad.,	℥xvi.

M. bene ut emulsio fiat.

Sig. "Emulsion codliver oil."

The great disadvantage of most emulsions of codliver and castor oils is that they are thick, slow-running, sticky preparations, which are swallowed with difficulty and leave an unpleasant taste behind them. The advantage of the alkaline emulsion mentioned above is that it is no thicker than milk, is smooth and slippery and is swallowed without any difficulty leaving little, if any disagreeable taste behind. An emulsion of castor oil made after the same plan has robbed the childhood of several little patients of one of the horrors of that period of existence. The formula for the emulsion is as follows:

Ol. Ricini,	℥ii.
Ol. Menth, Pip.,	m. v.

Aquæ, ... ℥i.
Sodii Carb. Exsiccat, ... gr. x.

Dissolve Sodii Carb. Exsiccat in water, add the oils, mix well by violent shaking and mark.

This preparation contains two-thirds oil by volume, and the dose can be proportioned accordingly.

WHY CERTAIN PILLS SHOULD NOT BE PRESCRIBED.

This city has lately been thoroughly canvassed by an agent of a manufacturer of certain pills. The advantage of these pills over others lies, it is claimed, in the fact that they are, essentially, powdered drugs, surrounded by a thin and readily soluble coating of sugar.

Let it be granted that these claims are true, why should reputable physicians refuse to prescribe them? Because the process by which they are made is kept *secret*. Secrecy in medicine, whether as to the character and constituents of a prescription or as to the mode of preparation, is a thing to be avoided in every possible manner. The truly scientific man who has the interest of the profession, which is the welfare of humanity, at heart, if he has discovered anything that will advance that interest, publishes it immediately to his brethren that they too may have the benefit of his discovery, whether that discovery be in the nature of a remedy itself or of a mode of preparation of a remedy.

It is a mean, selfish spirit, smacking of quackery, that will keep such a discovery secret for the purpose of making money; and the sooner such a spirit is stamped out of the profession, the better it will be for the profession itself and for humanity at large.

The development of this commercial spirit in the profession can be traced directly to the low standard, mental and moral, required by the medical schools of this country for admission to the ranks of a profession, which should require of its members the highest possible education in all directions.

The broad-minded and honorable thing for the manufacturers of the Upjohn or of any other pills to do, is to publish their mode of manufacture so that, if proved worthy, it can be incorporated in the next Pharmacopœia. If then the company showed that it manufactured its pills better than other makers, the physician would be justified in specifying the name in his prescriptions, just as now, on account of their superior make, he specifies *Squibb's* chloroform, *Wyeth's* Fl. Ext. of Ergot, *Parke, Davis & Co's*. Fl. Ext. of Cascara Sagrada, etc.

DeL. R.

OPENING OF THE OGDEN-ARNOT HOSPITAL, AT ELMIRA.

By the generosity of Mrs. Ogden and other members of the Arnot family, Elmira has been provided with a beautiful and well-equipped hospital, which was formally opened December 20th. The property deeded to the city by Mrs. Ogden, together with the endowments by other members of the Arnot family, aggragates $125,000. Besides the two beds, each endowed for $5,000, another has been endowed by Stephen T. Arnot and daughter, Mrs. Fannie Arnot Whitney, for $5,000. Mrs. G. G. Haven, a sister of Mrs. Ogden, also endows the institution with $25,000, to be known as the Arnot-Palmer fund, and Matthias H. Arnot endows it with $10,000.

Dr. W. C. Wey in accepting the gift, on behalf of the trustees, said:

> In behalf of the managers of the Arnot-Ogden Memorial Hospital, I accept these evidences of the transfer of the entire property from the hands of the originator and builder of this noble charity, to the posession and control of its authorized agents, who, from this hour, are to direct and govern its policy and administration.
>
> In assuming the guardianship of this hospital, the managers are profoundly impressed by the character and magnitude of the work, both charitable and compensatory, which it is capable of accomplishing for the relief of human suffering. A want long felt in our growing city, with its multiplied industries, its extended railroad facilities, and its ever-present dependent population, which the eye of faith had grown dim in looking for among the possibilities of humanitarian enterprise, is supplied by a simple legal formality, through the inspiration and the munificence of one who in the breadth of her charity, prescribes that this hospital shall be open to all for whose benefit it is intended, without regard to age, sex, color, creed or nationality.
>
> It is possible in a degree only, to convey to the giver of this legacy for the relief of physical distress the acknowledgement of the managers of the hospital, and of the community generally, in view of what it is capable of accomplishing in its infinite opportunities of mercy and beneficence.
>
> It has been said that "Hospitals are in some sort the measure of the civilization of the people." If this is true of hospitals in the abstract, what shall be said of that

higher and more comprehensive order of hospital construction which brings to the composition of the building for the sick, the most advanced ideas which have grown out of centuries of patient trial and experiment, perfected and made practically available under the genius of modern sanitary science.

Add to this the adaptation of all the devices which medicine and surgery have contributed for physical comfort under the bondage of disease, and the possibilities of recovery from accident and sickness, aided by designs and suggestions, harmoniously mingled, of benefactor, architect and builder, and the perfection of hospital arrangement and hospital expectation have been attained for the use of the people of the city of Elmira.

The managers will endeavor to administer the trust committed to them in the conduct of this hospital in the enlarged and generous spirit which has marked the efforts of its donor in the entire character of its design and equipment. This building is indeed "for all sorts and conditions of men." The extraordinary care taken to provide for the multifarious needs of the sick and the afflicted is a reflex of the benevolent and generous disposition which realized the necessity for such an institution in our city, and put in execution the means to build it on a scale and in a manner adapted to the wants of its inmates, and after the most approved standards of construction. Nothing has been omitted to make this building complete in every part. Its site has been chosen with a view, solely, to its sanitary excellence, and the location of the building combines features which are especially pleasing to the eye and encouraging in the restoration of disordered mind and body.

It has been said in language as fitting in this instance as when the words were uttered, "The place where the people pray and the place where they suffer are alike the house of God."

That God's blessing may rest upon this hospital and upon those who have been instrumental in bringing it into existence, as well as upon the men, women and children who are to be benefitted by its administrations, will be the prayer of all persons present on this auspicious occasion.

Drs. W. C. Wey, T. L. Squire and C. W. M. Brown have been chosen consulting physicians, and the active staff will be at present composed of Drs. Henry Flood, H. D. Pratt, Jr., C. L. Squire and H. D. Wey.

* * *

As an example of the drivel that may find its way into the public press, we reproduce the following, which seems to have been seriously quoted from the paper in which it first appeared, and to have found its way into numerous others :

A Suggestion for Jilted Lovers. — The late Dr. Henry F. Sands, recognized as authority in his profession, was not a believer in phrenology. His incredulity was shaken, however, by the following case: A gentleman of refined appearance came to him, declared himself as madly in love with a woman he could not marry, and insisted on a surgical operation. He declared that the blood drawn from that part of the skull said to indicate love would cure him of his passion. The surgeon, after much discussion, when fully convinced of the man's sanity, performed the operation. He bored two holes through the skull at the base of the brain and applied leeches. The man rose up temporarily cured, and from time to time as his love returned he applied the leeches. A word to the wise is sufficient — jilted lovers should carry a leech instead of a pistol.

* * *

THE next regular meeting of the Erie County Medical Society will take place Tuesday, January 8th, at the Young Men's Christian Association Building. A full attendance is urged.

* * *

THE annual meeting of the New York State Medical Society occurs February 5th–7th, at Albany. Dr. Hopkins, of this city, will present a paper during one of the sessions, and essays are expected from other Buffalo physicians.

* * *

THE MEDICAL PRESS is unavoidably late this month owing to the non-arrival of paper from the mill. A large order was placed several weeks ago for a better quality than we have been using, necessitating a special run to make it. The delay in freights we could not well avoid and so had to go to press with such paper as we had on hand.

Society Proceedings.

BUFFALO MEDICAL AND SURGICAL ASSOCIATION.

REPORTED BY W. A. HODDICK, M. D., SEC'Y PRO TEM.

Regular monthly meeting of the Buffalo Medical and Surgical Association, held December 4th, in the Mechanics Institute Building; President Van Peyma in the chair.

Drs. Rogers and Person were elected to membership.

Dr. F. H. Potter read a short essay on the "Treatment of Acute Coryza." He divided the treatment into (1) Preventative, (2) Remedial. Under the first head he advised the exclusion of night air from the sleeping apartments, as one of the chief prophylactic measures. Under or over-clothing the body should be avoided, and outer wraps are to be removed when indoors. The sealskin sacque was accountable for many colds. Clothing should be regulated to the temperature. Chronic throat and nasal disease should be attended to, also improve the general and constitutional conditions. (2) Remedial measures. If the attack comes on toward evening, it is recommended to give a warm bath followed by gr. 1-200 to 1-100 of Atropiæ sulphas or, if preferable, 10 grains of Quin. sulph. Next day cleanse the nose with a spray or douche, followed by applications of oleum petrolini. Treat locally by day reserving general treatment for the night. In favor of the parasitic origin of the disease is the fact that various bacteria have been found in the secretions.

Dr. Roswell Park then read a paper on "The Radical Cure of Hernia." After rehearsing some of the numerous methods of treatment that have been proposed in time past, he took up the modern surgical procedure advocated by various operators. He favored Czerny's method of ligating the sac as high up as possible, and exsecting the part below the ligature, in all cases except congenital herniæ. In this the lower portion is left and ligated or closed by suture, thus forming a tunica vaginalis for the testicle. The part between the ligature is then removed, beginning from below the pillars of the ring are brought together with wire suture, leaving a small opening at the bottom for the cord. The author at first made Czerny's shoe-lace suture with catgut, but this was later discarded for silk. At present he uses silver wire. The incision should be long enough, great care being taken to separate the cord from the sac. Intestines are replaced into the abdomen and the sac ligated as high up as possible. The silver sutures are twisted, the cut ends being turned inward. Femoral and umbilical herniæ are to be similarly treated. Extirpation of the sac is essential to success. In strangulated hernia, after relieving the strangulation, he proceeds in the same manner. He does not permit the wearing of a truss after the operation. The author had operated on 40 cases uncomplicated by strangulation or otherwise, with universal success. The patients were of all ages from five to sixty years. Six of the operations were for umbilical and eight for femoral herniæ. In one of the cases of umbilical hernia, a very stout woman, whose tumor hung down to the thighs, there existed a number of tumors in the sac with ulcerations on their surface. Fearing the tumors to be malignant, he at first declined to operate, but the patient assuming all risk, a laparotomy was made and the sac with its contents removed, closing the wound with three layers of sutures. Speedy recovery followed. Adherent pieces of omentum are to be loosened, securely ligated and cut off; especially if they cannot be easily replaced into the abdomen. Dr. Park took the position that hernia, with its attendant liability to strangulation, is more dangerous to life than the operation for its cure and therefor recomends it in all cases.

Dr. Park's full paper will appear in a future number.

Discussion.— Dr. Wheeler did not believe it best in acute coryza to exclude fresh air from the sleeping apartment. Pure air, even if night air, was beneficial. He suspected diet to be the frequent cause of the affection, and had observed that a brisk cathartic often hastened recovery. He was deeply interested in the subject of Dr. Park's paper. He had performed Heaton's operation in 12 cases, all of which he failed to permanently cure, and hence he had given up the operation. He had operated of late according to McBurney's method leaving the wound to heal by granulation. He unites the conjoined tendon to the skin and fastens the stump of the sac into the upper angle of the ring. The large cicatrical plug thus formed, he believed, effectually closed the ring.

Dr. Mynter agreed with Dr. Park as to the advisability of the operation. The two necessary adjuncts to success are, first, the extirpation of the sac, and second, the proper closure of the ring. He considered Ball's method of torsion of the sac of advantage in femoral hernia. He operates after the Czerny method, and at first used catgut sutures. He has operated in 60 cases of strangulated hernia with success. He considers it most important to remove the sac.

Dr. Potter gave the history of a case of strangulated umbilical hernia, part of the contents of which proved to be a lobe of the liver. The patient had been suffering with billiary vomiting, which was relieved after laparotomy and the successful cure of the hernia.

Dr. Mann, while not having had experience in the treatment of hernia, thought that any method that depended on a plug of cicatrical tissue for support would prove unsuccessful. After laparotomy, it was always the cicatrix left after the removal of the drainage tube which proved the weakest spot and permitted hernia to protrude. On this account he dreads the use of drainage tubes, but prefers to suture successively the peritoneum, the fascia, and finally the skin. On this account he considered Dr. Park's method peculiarly valuable and successful.

In closing the discussion, Dr. Potter said that by excluding night air, he did not mean that ventilation was to be neglected. The Scandinavians religiously exclude night air from their sleeping apartments, and coryza is almost unknown among them. Birds and animals warm the air they breathe by huddling together and placing their nostrils close to the skin. There should be no great variation in temperature between the living and sleeping apartments.

Dr. Park coincided with Dr. Mynter that the success of the operation for hernia depended on obliteration of the sac. Heaton's method was unscientific. The position of the sac is uncertain and the needle enters blindly. Umbilical hernia he had found most frequently in stout women. The hernial ring is generally small, but the tumor, itself, may spread out indefinitely between the layers of the abdominal walls.

Essayists for the next meeting were announced as Dr. Ernest Wende — "Parasitic Skin Diseases." Dr. W. C. Phelps — "Surgery of the Knee-Joint."

BUFFALO PATHOLOGICAL SOCIETY.

Regular meeting, November 23rd.

After transaction of some business the principal essay of the evening was read by Dr. B. H. Grove, on "The Relationships of the Eye in the General Practice of Medicine." (This has already appeared in the December number of The Medical Press.)

After the usual discussion upon the paper, Dr. DeLancy Rochester showed a specimen of gunshot wound of the heart; also a heart exhibiting well-marked insufficiency of the aortic valves from atheromatous disease.

Dr. Pryor presented a specimen of rupture of the aorta within the pericardium. There was no appearance of aneurism, but there was evidence of aortitis deformans with slight bulging from weakened coats of the vessel. The pericardium was found fiilled with firm fibrous clots and blood serum. Death occurred as the result of drink and exertion. He presented, also, an unique specimen showing malignant endocarditis affecting the aortic valves, with resultant aneurismal tumor of a leaflet, which had pressed upon the septum and caused a protrusion in the shape of a tumor, about as large as a bean, at the pulmonary orifice. Symptoms of malignant endocarditis were present and murmur of a pulmonary obstructive lesion was distinctly audible along with the aortic sound. The diagnosis had been made before death and was verified. This case adds one more to the few reported of pulmonary valve lesions in the adult, and the conditions which gave rise to it are noteworthy in a diagnostic way.

Dr. Park presented the following specimens: A foot which he had amputated from an elderly gentleman on account of epithelioma of the heel. The patient had suffered from severe frost-bite a number of years previously. On both heels obstinate ulcers had formed, and one of these ulcers had undergone malignant degeneration. Herein lay the chief interest of the specimen, since the possibility of this malignant transformation had been denied by men who claimed to speak with some authority. The speaker had, however, seen several instances of a similar nature, and could positively assert that it was by no means so very infrequent.

The next specimen was a fibroma removed from the abdominal wall of a middle-aged woman. It involved the entire thickness of the rectus of one side, and was so attached to the peritoneum that a portion of the same had to be removed along with it.

The third specimen was one of epithelioma of the prepuce and glans penis, necessitating amputation of the penis, in the case of an elderly man. Some infected glands in the groin were carefully extirpated at the same time. All the patients made rapid recoveries.

BUFFALO BOARD OF HEALTH.

At a meeting of the Board of Health, Dec. 13, 1888, Dr. Clark, the city health physician, read an interesting paper on "Tyrotoxicon," of which the following is a portion:

On the 4th day of last July and the day following, several physicians in Buffalo were called on to treat what appeared to be a peculiar form of poisoning, occurring in the persons of 25 or 30 individuals, representing seven or eight different families. After careful investigation it was assertained that all of the persons afflicted had partaken of ice cream which came from a certain well-known confectionery establishment on Main street.

Upon careful inquiry I learned that almost without exception, the patients presented the following symptoms, viz.: Vomiting and retching with diarrhœa of a watery character, severe griping pains in the stomach and abdomen, headache and prostration, with slightly accelerated pulse and temperature.

These symptoms closely resembled those produced by the injestion of many irritant poisons. They are also identical with the symptoms produced by what is known as ice cream poisoning or cheese poisoning; the toxic element here being a peculiar alkaloidal ptomanie called "Tyrotoxicon," or cheese poison, which Prof. Victor C. Vaughan first succeeded in isolating and naming. To my knowledge, no cases of poisoning from this cause have ever been recognized and reported in this city.

I was fortunate enough to procure a sample from the same lot of cream with which numerous customers had been supplied on the preceding day. This I sent to Prof. F. P. Vandenbergh, the city chemist, for analysis, with a request that he submit his report of the same in writing.

Cases of poisoning from eating ice cream are by no means as rare as people think. In the report of the Brooklyn Board of Health for 1885, an instance is given where over 100 persons were poisoned by ice cream which all came from a single restaurant. We can all call to mind the wholesale poisoning a few years ago at a Sunday-school picnic near Chicago, caused by eating ice cream. In the summer of 1886, a fearful poisoning from ice cream occurred at Leamington, N. J., and in September, 1887, Dr. Mesic, of Milan, Michigan, had four cases in one family, three of which proved fatal.

Tyrotoxicon is not perhaps the only poisonous ptomaine which developes in milk, cream, etc., but it is the one with which we are most familiar, and recent experiences prove that it sometimes exists in oysters which have been too long kept, and in which putrefactive changes have commenced. If this highly poisonous substance develops in milk, cream and oysters which are allowed to grow old before using, it is not unreasonable to suppose that it may develop in almost any article of food which will undergo decomposition.

Too much attention cannot be paid to the milk supply, for this and cream seem to offer all the essential conditions for the ready growth and development of tyrotoxicon. The principal reason why this noxious element is found in the ice cream used at picnics and on holidays is undoubtedly due to the fact that the manufacturers, in order to insure the necessary supply, keep the cream and milk on hand for three or four days before it is converted into ice cream. During this time the changes of decomposition occur, and one result is the development of this poisonous ptomaine.

It is a well-known fact that milk is very prone to decomposition, and will readily absorb odors from decaying substances. It is equally well known that milk is very carelessly handled and very poorly taken care of by many after it is received from the milk-man. These facts, together with the knowledge that many infants in all walks of life are nourished either partially or completely by cow's milk, would certainly warrant us in believing that in this poisonous ptomaine of decomposition, "Tyrotoxicon," we have one of the principal causes of cholera infantum.

I have long shared this opinion, and when we observe the symptoms produced in dogs and cats, and in the human being, by the ingestion of this poisonous substance we can at once perceive their striking resemblance to those observed in the cholera infantum of children. If we discontinue the poison, the symptoms after some time disappear; but we can bring them on at any time by again resorting to the tyrotoxicon.

Every physician of experience can bear me out in saying that in cholera infantum in its early stages, before the child's vitality becomes exhausted, marked improvement follows a complete stoppage of milk food. Even though the milk is strictly pure and fresh when given to the child, it may develop the poison of decomposition in the child's already irritable and disordered stomach. I have seen some of the worst cases recover in a surprisingly short time when milk was discontinued and meat juices and egg albumen substituted, along with a mild laxative and antacid preparation. This is known as the "no milk treatment," and is, I believe, the most rational treatment for this dangerous and fatal malady.

In using the term "cholera infantum" I do not refer to any and every form of "summer diarrhœa" which some physicians are pleased to call "cholera infantum;" but I restrict the term to the violent choleraic form, as is done by Smith and other good authorities on diseases of children.

The fact that cholera infantum is very largely confined to the children of the poorer classes in large cities is a very strong argument in favor of the theory that it is largely produced by decomposition changes in milk.

"By such people milk is often not obtained until it has begun to sour, then it is kept at a high temperature, and often in a most foul atmosphere. This milk is then eaten by the little ones who are weakened by poverty and everything that poverty means, insufficient food generally, and that of the poorest quality, insufficient clothing, insufficient and vitiated air. With these facts before us it is not surprising that in all our large cities thousands of children die annually from summer diarrhœas."

That great authority on infantile diseases, Smith, says that "Cholera infantum is a disease of the summer months, and, with exceptional cases, of the cities." Thus the disease occurs at a time when decomposition of milk takes place most readily. It occurs at places where absolutely fresh milk cannot often be obtained. It is most prevalent among classes of people whose surroundings are most favorable to fermentative changes. It is most certainly fatal at an age when there is the greatest susceptibility to the action of an irritant poison, and when irritative and nervous fevers are most easily induced. If all these facts be taken into consideration, along with the experiments which have been made and which show the readiness with which the poison can be generated, it will certainly seem at least probable that tyrotoxicon may be a cause of cholera infantum. A little dried milk formed along the seam of a tin pail, or a rubber nipple, tube or nursing bottle not thoroughly cleansed, may be the means of generating in a large quantity of milk enough of the poison to render it highly harmful to children. The high temperature observed in children with cholera infantum, and which has not been observed in adults poisoned by tyrotoxicon, may be caused by the continued production of the poison in the child's intestines by the continued administration of milk, and by the greater susceptibility of the sympatethic nervous system in children.

The notoriously defective plumbing in many of our city tenement houses affords many avenues for the entrance of poisonous gases, which aid very largely in bringing about putrefactive changes in food supplies, and particularly in milk and butter, owing to their great affinity for noxious odors. Very recently I have had occasion to examine some private residences in process of erection, and in two instances was surprised to have the proprietors tell me, that they intended to have the waste water from the refrigerator carried by direct pipe connected into the sewer, and this to save time and trouble. What a sad commentary on the intelligence of these last days of the nineteenth century! Save time and trouble and let in poison and disease.

The following rules, formulated essentially by Vaughn, are given herewith:

"1. Cows must not be fed upon swill, or the refuse of breweries, or glucose factories, or any other fermented food.

"2. Cows must not be allowed to drink stagnant water.

"3. Cows should not be heated and worried before being milked.

"4. The udders should be washed if at all dirty, before milking.

"5. The milk must be at once thoroughly cooled. This is best done by placing the milk can in a tank of cold spring water or in ice water, the water being of the same depth as the milk in the can. It would be well if the water in the tank could be kept flowing. This will be necessary unless ice water is used. The tank should be thoroughly cleaned every day to prevent bad odors. The can should remain uncovered during the cooling, and the milk should be gently stirred. The temperature should be reduced to 60 degrees F., within an hour. The can should remain in the cold water until ready for delivery.

"6. In summer when ready for delivery the top should be placed on the can, and a cloth wet in cool water should be spread over the can; or refrigerator cans may be used. At no season should the milk be frozen; but no buyer should receive milk which has a higher temperature than 65 degrees F.

"7. After the milk has been received by the consumer it should be kept in a perfectly clean place, free from dust, at a temperature not exceeding 60 degrees F. Milk should not be allowed to stand uncovered, even for a short time in sleeping or living rooms. In many of the better houses in the country and village, and occasionally in the cities, the drain from the refrigerator leads into a cess-pool or kitchen drain or into a sewer. This is highly dangerous ; there should be no connection between the refrigerator and any receptacle of filth.

"The only vessels in which milk should be kept are tin, glass or porcelain. After using the vessel, it should be scalded, and then if possible, exposed to the air."

The following is Prof. Vandenbergh's report:

To the Board of Health :

Gentlemen,— I respectfully submit the following report concerning a quantity of ice-cream, being a portion of some which produced serious illness in the families of several citizens.

The symptoms described by health physician Clark were sudden and severe, and of a character which would follow injection of an irritant poison. They were not such as would be produced by opium, morphine, strychnine, aconite, belladonna, and certain other vegetable poisons ; accordingly these were not sought for in the analysis.

The symptoms resembled those caused by arsenic but were even more like those produced by corrosive sublimate. A careful search showed that neither of these were present.

A few of our dairymen have used a solution of annatto in caustic potash to correct acidity and give a creamy tint to milk which has been skimmed.

An examination for these substances was made with negative results.

The other preservatives, baking soda, borax, boracic acid, and salicylic acid, which, in sufficient quantity would produce serious intestinal irritation, were not present in the cream submitted for analysis.

Such symptoms might also result from the milk of deseased cattle or from their improper feeding, but this was said to be the mixed milk of many cows and the means of information on these points were not at my command.

My attention was next directed to the separation of certain animal alkaloids or "ptomaines" which are sometimes found as intermediate products in the decomposition of milk, cream, cheese and butter.

From the remaining portion of ice-cream I succeeded in isolating a cluster of needle-shaped crystals which communicated to the tongue a sense of burning and afterwards of numbness. A few chemical tests were applied which showed the substance to be a ptomaine.

A large fragment of the substance was then placed upon my tongue and allowed to dissolve.

In about 20 minutes, I felt discomfort in the stomach which increased to decided nausea and a strong desire to vomit. These symptoms were accompanied by a peculiar dull headache and lack of desire for food during two meals.

Another portion of the material was given to each of two kittens about two months old. In a half-hour both were retching and purging violently and later laid upon the floor in a stupor.

They were first in violent pain and then unconscious, but after about two hours revived and the following morning seemed recovered, but were not playful.

The result of my examination shows that at some time there has been carelessness in cooling or transporting the milk from which this ice-cream was made, producing a variety of fermentation the product of which is an alkaloid-like substance known as tyrotoxicon, and which in my judgment was the cause of the symptoms described by Health Physician Clark.

F. P. VANDENBERGH, M. D.,
City Chemist.

Correspondence.

A VISIT TO NANCY.

LONDON, NOV. 23, 1888.

Dear Doctor.— While in Paris, one hears more or less about hypnotism, and rarely hears the subject discussed without hearing Bernheim's name mentioned ; and as a rule he is quoted in order to oppose his views. Acting on the theory, that a man who is constantly attacked by leading men must be a man worth seeing, I determined to go to Nancy and see the man for myself. While waiting for a favorable opportunity, I met Dr. Christian A. Herter, of New York City, at Charcot's clinic. He had just come from Zurich, where he had been studying hypnotism and psychiatry for nine months with Prof. Forel, who is a disciple of Bernheim. Dr. Herter had just finished the translation of the latter's book, and was enthusiastic in his praise of the Nancy School, and urged me to go and see for myself.

I accordingly wrote to Bernheim and asked him what he would do for me, if I went out there. He replied that he would do everything possible. Without much difficulty I persuaded four American and Scotch physicians to go with me. Prof. Bernheim received us most cordially, and offered to give us four hours a day in the hospital. For five days we spent the hours from eight until one o'clock in the wards with him.

It was a most peculiar clinic, almost an unearthly one, so contrary did it seem to reason and to any laws we might formulate. We went from bed to bed and saw all varieties of disease — respiratory, cardiac, abdominal, functional, etc. One after another they passed into the hypnotic state, and remained so until they were awakened by him.

His method of hypnotism is that of simple suggestion, and this for susceptible cases amounts to nothing more than the command to sleep. In 10 seconds the patient sleeps. In other cases the suggestion to sleep is accompanied by the pressure upon the closed eyelids and telling the patient that the lids are closed because he is asleep and that he cannot open them. Other patients, especially those who resist, or are hypnotized for the first time, have to be treated by the process known as fixation. The patient is seated in a comfortable chair with his back to the light, and the physician sits so that the light shines upon his eyes. The patient is then directed to look at the physician's eyes, which reflect the light. After a few minutes the patient's lids feel heavy and he obeys the natural impulse of letting them droop. The physician then places two fingers before the patient's eyes, directs him to look at them. The fingers are then moved slowly downwards. After perhaps a minute the lids droop some and close. The physician places his fingers lightly on the lids and tells his patient that he is almost asleep, and that he cannot keep his eyes open, that he cannot open them if he wishes to. In a little while, varying from 10 seconds to two minutes, the muscles relax, the breathing becomes slower and deeper, the physician gives the order to sleep, and the patient is in the condition known as hypnotic sleep. In many instances, Bernheim talks in a monotone to the patient, much after this formula: "You begin to feel your lids growing heavy. Your pupils are opening wider and wider, and the light tires your eyes, they are becoming moist; you want to close your lids; let them fall! Your limbs feel so tired and heavy, they begin to be numb, and you are so sleepy; then sleep!" And the patient obeys.

What class of patients does he choose for hypnotism? He does not choose at all. We saw him hypnotise men, women, children, infants, the sick and the healthy, the educated and the ignorant. The youngest person hypnotised was an infant of 20 months. The oldest was a grey haired man.

The facility with which many came under his influence was of course most marked in those patients whom I will designate as "trained," that is persons who have been hypnotised many times. These people go to sleep on the simple command sleep. Those who are hypnotised for the first time are those who show the possibilities of this agent and the cases which enable us to study the condition in its pure form, that is hypnotism minus training or hypnotism without simulation.

What then are the phenomena we notice? The patient is to all appearances enjoying a natural sleep. If he is a good subject, he can be made cataleptic by suggestion, *i. e.*, telling him that he cannot move his arm from a certain fixed position, and he cannot. They can be put in the somnambulistic state, *i. e.*, they are able to talk and carry on a conversation with you. They receive suggestions and obey. Their senses receive impressions. In examining carefully we find the patient is anæsthetic. He can be pricked, pinched, burned, his joints twisted, without producing pain. Mucous membranes of such sensitiveness as the conjunctivæ and nasal membrane can be irritated without producing their characteristic reflexes.

But what havoc has been played with the special senses! He hears, not what we hear, but what he is told. He hears, feels, tastes, smells and sees only what is suggested. For instance the patient is given a finger and he is told it is a glass of beer, and he drinks as if with relish. He eats imaginary food. If he is told that there is music he hears it though there is none, and his facial expression is in harmony with the character of the music suggested. The contrary is also possible. If the suggestion is given that he is deaf, he hears nothing, So with the eye. In a room full of patients, and in bed surrounded by half a dozen men, the suggestion was given that he was alone with Bernheim and that no one else was there, and the presence of the others made no impression upon him. Their own identity can be suggested away, and they are for a time being other persons. Their sense of right and wrong, their judgment in all things, is entirely at the mercy and will of the hypnotiser. The power of the suggestion is not limited by the hypnotic state, for there are a large number of persons who perform suggested acts in the past hypnotic state. For example, a person is hypnotised and it is suggested to him that two hours after awaking he will undress himself and go to bed. That suggestion will be carried out. In fact, I saw most complicated suggestions carried out to their minutest detail, the patient being ignorant that these acts were suggested.

Now all this recital is very curious and would be perhaps an unwarranted trespass upon your space, if there were not a therapeutic lesson to be learned. I have been giving, if I may be allowed the expression, the physiological action of a therepeutic agent. Now I should like to speak of its therapeutic use. Nowhere is this means of treatment more used than at Nancy, and for such a variety of ills.

Bernheim, though not claiming for suggestion that it is a cure-all, nevertheless uses it for experimental purposes in all diseases. He does this in order to fix its proper limits and to define its powers. He disclaims Charcot's views that the suggested sleep "Le petit hypnotism," as Charcot calls it, is a hysterical disease or that it will induce disease; so he uses it freely, and, as he says, with good results in certain diseases.

In a girl who had severe pain along the right sciatic nerve, and pain on pressure over the point of exit of nerve, the diagnosis of sciatica was made. She was ordered hypnotism twice a day. At Bernheim's request I hypnotised her and suggested that when she awoke she would have no pain. After awaking her I pressed upon the nerve. She did not wince and said she felt no pain. This treatment will be continued for two weeks, then she will be hypnotised at greater intervals till the pain is permanently removed.

Another patient, a boy of 17, suffering from nocturnal enuresis since birth, came to the hospital for treatment. He was hypnotised and the suggestion given him that he would retain his urine till morning. The suggestion was repeated for three different nights and the patient slept each night in a dry bed.

This class of cases has been especially marked by success. From the nature of the disease one can readily understand that if any benefit can be derived from hypnotism it ought to be in this nervous bladder affection.

Cases of asthma are often treated with success. Rheumatism is also treated with the result of freedom from pain for a time. Writer's cramp, he reports as relieved and sometimes cured. Chronic gastritis, dilatation and vomiting—treated by suggestion—result in great amelioration, various myalgias, and neuralgias are reported cured.

I have thus far given reports principally of cases I have seen, and also quoted a few cases Prof. Bernheim reported, but I have still the duty of relating my impressions and the result of certain investigations. In the first place, does Bernheim do all he claims to? After having carefully observed over 80 patients whom he hypnotized, I interrogated each one and watched others, when Prof. Bernheim was in other wards.

I found some whom I suspected of simulation, and accordingly I went to them with the simple statement that I wanted to know why they pretended to sleep, that they need not be afraid to tell me the truth as I was an American physician and was there for the sole purpose of studying the subject. Three of these people acknowledged that they simulated and said they did it to please Prof. Bernheim. One of these cases was a young woman with chronic cystitis, another an old woman with cancer, and a third an old man. Two other patients I was satisfied simulated, one a little girl of eleven, and another, a man of about 40, suffering with tabes.

These patients appeared to sleep and went through a number of automatic acts and appeared to be anæsthetic, but there was an indescribable something which caused me to suspect them, and when the others left the ward I remained behind to watch them. No sooner had the patient made sure that Prof. Bernheim had left the ward than the subject opened his eyes and commenced to laugh.

This was true of the five cases mentioned. There were others where doubts existed but where nothing could be proved.

That all of his patients under treatment will get well I very much doubt. In fact, I cannot believe in its efficiency in any but functional diseases. I make this statement, fully aware of the vaso-motor phenomena which can be produced, as the raising of a blister by the application of a postage stamp and suggesting that it is a fly blister. But such cases are too rare to guide us. I should like to speak of the use of hypnotism at Paris, where Bernheim is most opposed, and should like to speak of the great dangers and abuses which may arise from its general use, did time permit.
J. W. PUTNAM.

ACCORDING to the clinical tests quoted by Erlenmeyer and Reissner, the chief special value of narceine is in its use as a sedative and hypnotic in psychiatric diseases; on which field of practice it has, in most cases, yielded results superior to those of morphine.

Also for a hypnotic and sedative in general, it has proved exceedingly valuable: according to Debout's reports, a dose as small as 0.03 gramme (½ grain) suffices to induce a quiet sleep without oppressive dreams, and not followed by headache on awaking.—*Merck's Bullitin.*

Translations.

THE ILLNESS OF EMPEROR FREDERICK III.

From Official Reports by Profs. Bardeleben, Von Bergmann, Dr. Bramann, Profs. Gerhardt, Kussmaul, Drs. Landgraf, Moritz, Schmidt, Profs. Schrœtter, Tobold and Waldeyer.

Especially Translated for "The Medical Press" from the "Deustche Med. Wochenschrift."

(CONTINUED FROM PAGE 545, VOL. III.)

The abundance of the expectoration led Prof. Von Bergmann to suspect the possibility of a lung affection. If this suspicion was well founded, the necessary precautions for the complication must be taken at once. This caused him to express a desire of having a physical diagnostician called. Besides he was satisfied with the diagnosis of ulcerative carcinoma, which was breaking down. It was no longer a case for a throat specialist, but should rather be under the care of a clinician, especially since general symptoms were beginning to develop. It was unanimously decided to recommend to their royal master that Dr. Kussmaul should be called, which proposition was immediately accepted.

On the 25th of February, Dr. Kussmaul became associated with the physicians in the case. He concluded, from the result of his examination, that the expectoration did not arise from the lungs or bronchi. He attributed the larynx as the probable source of the bloody mucous discharge, the ulceration and the epithelial swelling. He did not conceal the fact from Mackenzie that he regarded the tumor in the larynx as a malignant epitheleoma. Mackenzie did not deny the possibility of this opinion, but would not admit the certainty of the diagnosis. The last mentioned conversation of Kussmaul with Mackenzie again showed that the latter still continued to believe in the non-carcinomatous nature of the growth. But he declared that if an authority like Virchow would substantiate the preparations made by Von Bergmann and Bramann, he would then be convinced.

Virchow was then in Egypt, could not be reached and another authority had to be proposed. By this time many experiments had been made with variously carved canulæ, some covered with fine rubber, so that an agreement concerning the canula question was reached, Mackenzie declaring himself satisfied with one lately introduced. As the wound about the canula had long since cicatrized, the duties of Von Bergmann, as surgeon, were considered as ended. On his return to Berlin he promised to take the reserved preparations to Prof. Waldeyer, one of the best acknowledged authorities on the evolution of cancer. To this Mackenzie submitted and agreed to accept Waldeyer's decision. On the morning of February 28th, Von Bergmann was ready to return, when a telegram from His Majesty the Emperor detained him at San Remo. "His Majesty wishes you to remain until the arrival of His Royal Highness Prince Wilhelm on March 2nd." It sought to obtain a binding promise with regard to an early return of the royal patient to Berlin. To fulfil this decidedly expressed wish of His Majesty, Von Bergmann saw but one means, that was to convince Mackenzie of the correctness of the diagnosis of cancer. He believed that Mackenzie would then give up his objection to the returning home of the royal patient, which was not to be a direct journey to Berlin since stops were to be made at Baden-Baden or Wiesbaden. Von Bergmann, therefore, requested Prof. Waldeyer to come to San Remo. Prof. Waldeyer arrived on the evening of March 3rd. He devoted the following day to a most thorough investigation which resulted in the fullest corroboration of Von Bergmann's opinion in regard to the microscopical examination.

Prof. Waldeyer's conclusions were as follows:

I. The concentric bodies (pearly, onion-like, cone-like) found are without doubt the so-called cancroid bodies originating from a cancerous growth.

II. The cancerous growth must be within the air passages, unless there is a communication between the air passages and a cancer situated elsewhere.

III. Its location is in all probably in the larynx above the canula.

IV. An extensive ulceration and necrotic breaking down of the cancerous growth must be taking place, which destruction has also involved the organ affected, the larynx.

Prof. Von Bergmann took Mackenzie to Waldeyer who explained to him in detail the signification of the microscopic revelation, demonstrating the diagnosis of cancer from the preparations made.

Mackenzie again asserted, as on the 19th of November, that he now had no doubt of the existence of cancer. Von Bergmann then urged a homeward journey, and succeeded in obtaining from Mackenzie in writing the following promise: "Owing to the manifestations of grave symptoms in the illness of his Imperial and Royal Highness, I, the undersigned, promise to urge his immediate return to Germany, which with the return of the warmer season I will in any case recommend.

MORELL MACKENZIE."

The result of one of the last consultations was the drawing up of the bulletin of March 6th, which has been so variously interpreted. "The undersigned declared that with regard to the nature of the illness of His Imperial and Royal Highness and its diagnosis, there existed no difference of opinion, nor was it maintained that a serious change was imminent. The entire responsibility for the treatment, as before the operation, is in the hands of Sir Morell Mackenzie, one of the undersigned."

Prof. Von Bergmann proposed that the contents of Waldeyer's opinion be kept secret, since His Royal Highness had so often been assured that the physicians had been in error on November 9th, and there existed a laryngeal affection to be cured by tracheotomy. Up to that time the press had not received notice of the decided anatomical diagnosis of Von Bergmann and Waldeyer. The newspapers interpreted the bulletin as acknowledging the favorable judgment of Mackenzie. The events which took place on the 6th of March, with their due consequences, are well known. On the morning of the 10th, Emperor Frederick III, started on his homeward journey, arriving at the castle at Charlottenburg on the evening of the 11th. Eight days after the return, Dr. Wegner invited Von Bergmann by letter to examine and assist in the treatment of His Majesty, after Mackenzie had been entrusted by an imperial order with the exclusive responsibility and managment of the case.

Repeated examinations between March 18th and May 8th convinced Prof. Von Bergmann that the destructive process was increasing. On the 8th of March, Mackenzie found the skin replaced above and to the side of the canula by a redish-yellow wart-like growth about 5 mm. in height. Part of it was dark brown and visibly gangrenous, while another part was glazed with blood. The density and the deep furrows of the same characterized it as an exuberant cancerous mass. This Mackenzie denied, saying: "They certainly are not cancerous but only wound granulations." The canula that Mackenzie used at the time consisted of a straight smooth silver shell 4 cm. in length through which the inner tube was pushed by means of a strong mandril. The inner tube was about 6 cm. longer than the outer one. With the exception of the part projecting externally it was movable, being constructed of pieces on the principle of a lobster's tail. The outer and straight canula was to reach into the lumen of the trachea. The movable part of the inner tube hanging down into the trachea. In this manner it was hoped to prevent any contact with the walls of the trachea. Prof. Von Bergmann called Mackenzie's attention to the fact, owing to the shortness and straight position of the outer tube, that the rapidly increasing growth of the tumor would push it easily out of the wound. A curved double canula, one which would have reached deep into the lumen of the trachea, would have guarded against this. But no notice of this advice was received by the physician in charge.

On the 12th of April Von Bergmann was sought by the nurse whom he had appointed in San Remo to take charge of the royal patient. The nurse informed him that the night just past had been a very bad one. The introduction of the inner canula was impossible, and the breathing of the Emperor was exceedingly difficult. About 3 o'clock the following letter from Mackenzie was brought to him by a royal courier, who met him, not at his home, but at a consultation in one of the hotels of the city:

"Dear Professor V. Bergmann.—We have difficulties with the canula and I shall be glad if you will see the Emperor with me *as soon as possible.* Yours truly,

MORELL MACKENZIE."

The last four words were underlined. Prof. Von Bergmann left immediately, accompanied by Dr. Bramann, stopping but a few moments at his residence to procure a few instruments. Here a telephone message from the castle was found asking his hired help whether the courier had found him, and requested that Von Bergmann should make haste. Scarcely had he left when another telephone message arrived, asking if he was on his way. He was received by the house-physician, Dr. Wegner, and found that he had written in his report: "The night was restless. In the morning there was tightness of the chest. On the removal of the canula respiration became easier; also after the introduction of a shorter canula. From one o'clock at night and throughout the day there had been dyspnoea. The canula projected partly, as Beerbaum, the nurse, had personally noted during the night. Respirations were greatly hindered." Von Bergmann was immediately taken to Mackenzie, who was found busy in the ante-room of the Emperor's apartments with one of Windler's instrument makers, trying to bend a leaden tube so that it could be pushed deep into the trachea. Thus he hoped to quickly make a fitting canula. Von Bergmann showed him one of Hahn's spongy canulæ which he had with him and which had precisely the same curve as the one he now considered as having the proper curvature. He at the same time removed the sponge. Mackenzie agreed that an attempt be made to introduce this, and both hurried to the King. The royal patient sat upon a chair, almost suffocating. His cheeks and lips were blue with stridor at each inspiration, which could be heard in the next room — a most exhausting inspiration, with great muscular exertion and drawing in of the scrobiculus, plainly visible under his opened coat. Von Bergmann believed that no time should be lost, and on obtaining Mackenzie's consent directed a servant to call Dr. Bramann, his assistant. He then began to examine into the wound. All about the canula there were warty growths which in the mean time had become much higher and broader. More or less had become gangrenous. The induration had spread throughout the deeper parts so that the region of the throat in which the canula lay projected like a short blunt cone. In the channel of the wound stuck only the outer tube. Upon asking how long a time had elapsed since the introduction of the inner canula was no longer possible, one of the servants answered, "Since early this morning." Mackenzie added that several attempts had been made to reintroduce it but in vain. While on Sunday, but four days previous, the posterior wall of the trachea could be seen in the depth of the wound, now no vestige of the same could be discovered. Certain round, redish excresences arose from the depth and sides of the channel of the wound and completely obstructed the passage to the opening in the trachea. The outer tube reached only to, but not into the trachea. Prof. Von Bergmann attempted to introduce the canula but did not succeed. The whole canal was filled with the aforesaid broad and greatly projecting granulations and prevented it. He set aside the canula and took up the wound hooks. In the meanwhile Dr. Bramann had arrived and undertook the holding of the hooks. Again Von Bergmann failed to push the canula into place, while the respiration became more and more critical. After first disenfecting his fingers in a dish of carbolized water that stood beside him, he endeavored to clear away the obstructing fungosities in order to reach the trachael opening and to place a hook into it.

[TO BE CONCLUDED IN OUR NEXT ISSUE.]

Book Reviews.

A TREATISE ON THE DISEASES OF WOMEN. For the use of Students and Practitioners. By A. J. C. Skene, M. D. Pp. 950. New York: D. Appleton & Co.

We welcome this work both because of the name on the title page and because there really is a need of a new student's text book in gynecology. Nor after a careful examination of the book are we disappointed. Dr Skene fully sustains his high reputation as a writer and teacher. A feature not often met with in modern text books is introduced. At the close of many of the chapters are found reported a number of illustrative cases with details of diagnosis and treatment. In this way many points are brought out not likely to be mentioned in the ordinary description of a disease, and the proper adaptation of methods to cases is well-shown.

Besides the subjects usually treated in text books of this kind, we find valuable chapters on diseases of the bladder and urethra, on the menopause, and on gynecology as related to insanity in women. A chapter is also added on the abuse of pessaries although the author is a strong advocate of their proper use.

There is much original work and many views peculiar to the author, but these views are generally sound and are based on large experience and close observation.

Naturally one turns to some of the vexed questions of the day to see how they are handled, but here we are somewhat disappointed. With Alexander's operation and hysterorrhaphy, the author has had no experience and therefore expresses no opinion. He is a strong believer in pessaries and thinks most curable cases can be cured without any operation. Vaginal hysterectomy is mentioned only in quotation, and Battey's operation is rarely alluded to.

These are at first-sight glaring omissions and are to be regretted, as the opinion of so competent a surgeon and teacher, founded on his own experience, would be of great value. Still the book was not written for specialists and these omissions do not detract from its value to the student and general practitioner.

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A very pleasing feature is the introduction of many new illustrations and the banishing of so many of the false and graven images which have done duty so long and which have served to confuse rather than make clear,

The book is well-printed in large clear type and is, we can honestly say, the best students' text book on gynecology of the day.

Diseases of the Liver. By Prof. Dujardin-Beaumetz. Detroit: Geo. S. Davis, 1888.

In this book the author has happily blended considerations of the physiology and pathology of a mysterious organ; and his therapeutics based, not only on the suggestions of many observers in varied fields, but also on his own large experience, are concise, generally practical, and stated in an original and pleasing style.

The work does not seem to have suffered from Dr. Hurd's excellent translation, and, altogether, the production is creditable to author, translator and publisher.

The Ear and Its Diseases, being Practical Contributions to the Study of Otology. By Samuel Sexton, M. D. Edited by Christopher J. Colles, M. D. Octavo, 473 pages. Numerous illustrations. Extra muslin, $4.00 New York: William Wood & Co. Buffalo: J. H. Matteson.

The author in this work has done for otology what has been done in an all too limited extent in other fields of medicine of late years — presented the salient points of his own experience and conclusions, on many interesting and debatable points, in a thorough and detailed manner, without going over in form or substance much that is "stock" in all treatises on the subject. The book bears the imprint of the author's personality, and of his profound pathological knowledge in this field, with a broad conception of the relations of ear disease to general physical conditions — relations too often overlooked or ignored by the precise but narrow localist. While these desirable features of the book may confine the field of its usefulness to readers already more or less familiar with otology, to these it is most thoughtful and suggestive.

Among the subjects considered at length, that are touched but slightly or not at all in the standard treatises, may be mentioned first, the remarks on the role of the exterior muscles and fasciae of the ear in maintaining the normal tension of ths drum membrane, and the cases illustrating this physiological point by pathological conditions. The chapter on "The Sense of Hearing" is most suggestive and incidentally illustrates the wonderful correlation of all branches of knowledge in modern life in its analogies from the physics of the telephone. Some interesting theories as to the causation and character of anomalies of audition (autophonia, tinnitus, etc.) are advanced later in the book, with illustrating notes of their effects upon musicians, public speakers and singers. Especially practical is the section on the relation of certain aural phenomena to insanity. The opinions on catarrh of the upper air tract, already known from the author's contributions to current literature, are broad and philosophic. Perhaps in the stress just laid on the constitutional aspects of this question, some plainly local and mechanical influences, well recognized by rhinologists, receive too scanty notice; but a strong stand for the consideration of the individual as well as of the local disease is needed at this time, as is shown by current laryngological and otological literature. The causative influence of dentition and of deseased teeth is aptly shown by tables compiled from the author's practice, and by constant clinical evidence throughout the book. The conclusions as to the injury from certain appliances in dentistry, and from "dead teeth" at times, however skillful their mechanical treatment, are of practical interest in this era of dental experimentation. The observations on the effects of heavy artillery firing, explosions, etc., are novel and interesting. The etiology of othæmatoma is exhaustively considered with a conclusion in favor of its traumatic origin in every case. The few remarks on defective hearing in school-teachers present a new side of a well-considered question. The claims for pensions, a question of timely and practical interest, receive fair consideration from one unusually qualified to write upon the subject.

The most interesting and original topic considered by the author is the operation of excision of the drum-head and ossicles. This procedure represents the greatest advance — indeed the only advance, unless the "dry treatment" be so considered — of aural surgery in the line of modern surgical development. It is founded — especially as applied to chronic suppurating ears — on sound general surgical principles, and the wonder is that it has not had earlier application. In 1873, Schwartze extracted the malleus in a case of schlerosis, and Kessel, Lucæ, Kretschmann and Stacke had performed the operation abroad, as is carefully explained by the author, before he had attempted it. However, Dr. Sexton was led by his own independent observations to undertake the operation before he was aware of the work already done in this field, and the credit of brilliant achievement from original research is his. We may be proud that American otology shows itself so well to the front in this practical advance. Dr Sexton appears to have approached the subject more from its surgical aspect in suppurative cases, and to have been led by the excellent effect upon the hearing to apply it to chronic non-perforating otitis — the reverse of the apparent mental process in Germany. An interesting table of 29 cases, operated on from March, 1886 to February, 1887. for long standing and intractable (by classic methods) purulent inflammation, shows 15 cures and 13 more or less improved in discharge, hearing and tinnitus. A report of eight cases of non-perforating otitis operated on, shows improvement of hearing and tinnitus in all — in some great and speedy improvement. No dangerous or unfortunate results have been met with. This operation, better than any method yet reported, obtains that patency of the drum-membrane that has been the goal of the otologist in certain non-supurative cases. Indeed, it is the only method in which failure appears not to be the rule. Dr. Sexton has presented to the American profession an increased incentive to further effort to relieve two classes of sufferers from ear disease that have heretofore been our opprobrium. In place of empirical dallying with various applications is offered a sound principle for guidance in selected cases.

The publishers have presented the subject matter in attractive form with good clear print and excellent illustrations. A few inexcusable slips of the proof-reader mar the otherwise excellent typography.

HAND-BOOK OF HISTORICAL AND GEOGRAPHICAL PHTHISIOLOGY, with Special Reference to the Distribution of Consumption in the United States. By George A. Evans, M. D. New York: D. Appleton & Co., 1888.

The scope and aims of this valuable book are so clearly defined by the title that extended reference to widen the views seems superfluous. The mass of information is admirably arranged and concisely stated. A short historical sketch relates succinctly the progress of pathological study and the chapters upon etiology are devoted largely to deductions based upon a careful grouping of salient facts. Attention will be invited principally to the collection of statistical data relating to the geographical distribution of phthisis and the topography and climatology of the different states. Much of the material has been gleaned from Hirsch and the "Tenth U. S. Census Reports," but the task must have involved considerable labor. To one unfamiliar with the widespread prevalence of consumption the array of facts will appear somewhat surprising. No climatic condition seems to control the social phase of causation and the reader is apt to revise opinions as to "change of air" and give deeper thoughts to other agents for relief. Much abused Buffalo shows a relatively low death rate from the dread disease, and it becomes evident that the region of the upper lakes has been maligned. Recent literature relating to climatic treatment of phthisis has aroused doubt in the mind of the experienced, and the facts and figures presented here only tend to increase the difficulty of the problem. Continued study of meteorology seems to demonstrate the unreliability of atmospheric influence alone as a curative agent, and that social environment is a more potent factor in the development of phthisis than cloudy days, humid air and damp soil.

Trustworthy information in this direction is sadly needed, and the author furnishes a fund of knowledge, detailed and accurate, which will cause reflection and win special interest at this time when the pathology and treatment of the universal scourge are attracting intelligent inquiry and investigation.

MEDICAL DIAGNOSIS. A Manual of Clinical Methods. By J. Graham Brown, M. D., Fellow of the Royal College of Physicians, of Edinburgh. Second Edition. Illustrated. New York: E. B. Treat, 1888.

There should be a strong reason for the appearance of a new handbook on medical diagnosis. Apparently this work has won acceptance and earned a second edition. As a guide to the young physician or student, it will serve a purpose and supply essential points covering an extensive range of subjects. Considered in that relation it becomes one of the many text books from which the student may select. The style is clear and concise, and the material abundant and carefully sifted. Where brevity is necessary, consideration is apt to be superficial, but the hurried glance may stimulate a desire for larger fields where discussion is more thorough and information more replete.

BOOKS RECEIVED.

From E. S. Werner, New York:
  The Case of Emperor Frederick III.

From Geo. S. Davis, Detroit:
  Hysteria and Epilepsy: J. L. CORNING.
  Diseases of the Kidneys: DUJARDIN BEAUMETZ.

Lectures on Ectopie, Pregnancy and Pelvic Hæmatocele: LAWSON TAIT.

From F. A. Davis, Philadelphia:
  Medical Bulletin Visiting List.

NOTICE.

In order to make THE MEDICAL PRESS of greater value to our readers, we offer to print, for not more than two insertions, three-line notices of wants, exchanges, practices for sale, etc., *free of charge.* Such notices should be received by the fifteenth of each month.

WANTS, EXCHANGES, &c.

To Exchange.—For other microscopic preparations. Mountings of nearly all the pathogenic bacteria. Also, cultivations of same in gelatine or agar-agar, for sale or exchange. Address the Editor.

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THE RADICAL CURE OF HERNIA.

BY ROSWELL PARK, M. D.
Prof. of Surgery, Med. Dept., Univ. of Buffalo.

[Read before the Buffalo Medical and Surgical Association at its December meeting.]

Ever since the early days of surgery efforts have been made to devise ways and means of retaining, more or less permanently, hernial protrusions from the abdomen. Trusses and the operations for strangulated hernia were known to the ancients and to the surgeons of the middle ages. As the anatomy of the parts concerned became better known, and as the general principles of operative surgery were more strictly laid down, operative measures began to be described by which the desired result might be gained. To treat of these in detail would be to weary you; it is enough to say that their general purpose was the occlusion or the plugging of the hernial outlet.

Of course when we deal with hernia, we deal with an open canal and open rings, and the end to be gained is the closure or the stopping up of these, so that the abdominal contents can no longer escape through them; whether this be done by causing adhesive inflammation by the injection of irritants, or by obliterating them with plugs of tissue from neighboring parts, or by sewing up the openings, has been in the past to a large degree a matter of choice with the surgeon who operated. Each method has had at times its advocates and its enemies, and each has been modified in some way by him whose name it bears. In former days the testicles were often removed along with the hernial sac, and this practice was so frequent during the seventeenth century that Dionis relates that an itinerant operator was in the habit of feeding his dogs with these organs which he had thus removed. Not less cruel were some of the other and more modern devices resorted to for a cure of rupture. Gerdy, whose method was at one time in considerable vogue, practiced invagination of the integument into the inguinal canal and its retention there by two sutures. The pouch of inverted skin was then denuded of its epithelium by strong ammonia, after which the raw surfaces were expected to unite under pressure. This operation was, in the light of our present knowledge, equally unscientific and unsuccessful and it has often proved fatal. Velpeau, Pancoast and others have injected tincture of iodine into the sac, after total reduction of its contents with a portion of its neck. This method of course is now mentioned only to be condemned. Wutzer, of Bonn, introduced in 1838 an improvement of Gerdy's method, having devised an instrument especially for this purpose. A wooden cylinder was used instead of the finger to invaginate the skin of the scrotum into the inguinal canal. Through the end of this plug a curved needle was forced up through the layers of integument, and over it a wooden shield or cover was secured by a clamp and allowed to remain until the desired adhesive inflammation was obtained. I am able to show you here one of the original Wutzer instruments which has in times past done as good work as this method will allow.

Passing over the various modifications of this operation, we come to the method of Dr. John Wood, of London, which consisted of a subcutaneous approximation, by a wire suture, of the tendinous structures around the inguinal canal and the consequent obliteration of that passageway. Prof. Wood has of late years modified his earlier operation in some of its details though its general plan is about the same. History repeats itself constantly and this operation which was successful in Prof. Wood's hands has signally failed in those of most others. A most ingenious modification of this method was suggested by the late Prof. Dowell, of Galveston. He closed the external inguinal ring by three subcutaneous interrupted sutures introduced with a peculiar needle. When I first saw this method demonstrated it seemed to me to be the coming operation, but almost every one who has tried it has been disappointed, because the cicatrical tissue intended to occlude the ring gradually stretches and the old condition once more returns.

Next we must mention the method known as the Heatonian. This consists in the injection of an irritating decoction of white oak bark into the cellular tissue around the hernial sac, with the intention of deliberately provoking a reactionary inflammation and causing its plastic products to occlude the canal and sac by compression. It is applicable only to cases of reduceable hernia and in execution is the simplest method of all. It is not without its dangers and death has been in a few cases the result of the inflammation thus set up. Having never been devoted to it myself, I prefer to let those more familiar with it speak of such merits as it posesses. For my own part, while recognizing those merits, I must say that I vastly prefer the operation which I shall subsequently detail, and for reasons which I will try to make plain.

In 1861 the late Prof. Gross operated by closing the external ring with interrupted wire sutures, but so far as I can learn contented himself with this and did not attack the hernial sac. In the edition of his "Surgery" of 1872 he speaks of what he had done as being the most direct and rational way of operating for radical cure. But to Czerny, of Heidelberg, belongs the credit of devising and recommending an effective and radical measure for the cure of this infirmity. This he did in 1877, and while his proceedures have been somewhat modified by other operators the general idea upon which his method is based has not been improved upon. His proceedure includes two different features; first, the isolation and extirpation of the hernial sac, and second, the effective and permanent closure of the hernial rings or outlets. If the sac contain adherent omentum or intestine, adhesions must be separated and intestine returned; omentum may be either returned or ligated and removed. If there be no adhesions complete reduction of the hernia is of course made before the extirpation of the sac be carried out. In cases of congenital inguinal hernia the sac must not be extirpated, because to do that would be to extirpate the tunica vaginalis. In such a case the sac should be separated from the spermatic cord, ligited near the testis and near its neck, and the intervening portion divided or, if long, be extirpated.

Before describing at length the procedure which I now almost invariably follow, I desire to give very briefly a few of the other operations that are practiced by surgeons, domestic and foreign, with more or less benefit to the patient.

In the *British Medical Journal* of December 10, 1887, Dr. C. B. Ball has described a method of obliterating the sac by giving it a number of twists after it has been isolated from its surroundings. This method of torsion is quite similar to that employed upon arteries and is practiced with virtually the same intent. After the twisting the sac lies coiled up in the neighborhood of the internal ring and is supposed to act as a plug by which that opening may be occluded. It has been found that, when this torsion is practiced, a ligature is unnecessary, though for my part I should prefer to ligate the neck of the sac no matter whatever else is done to it. In the journal above quoted, Ball reports twenty-two personal cases with three partial failures.

Prof. Macewen has described at length, in the *Annals of Surgery* for August, 1886, a method of operating peculiar to himself. He separates the sac well up to the internal ring, then doubles it into folds, thus making a sort of plicated cushion through which a catgut suture is passed, by means of which the folds are held together. He then separates the peritoneum a little way around the internal ring and sews this folded-up sac into or about the opening. After this he closes the inguinal canal with sutures. He does not allow patients to leave their beds until six or eight weeks have elapsed, and not even then does he permit them to engage in severe labor. He has reported eighty-one cases with one death and aside from this no failure. The minute details of his operation can only be understood by reference to his diagrams in the paper just alluded to.

Dr. McBurney, of New York, is in the habit of practicing what we may call an open method of treating these cases. He first extirpates the sac and then leaves open the wound, including the external abdominal ring, and awaits closure by granulation with its ensuing cicatrization. It will be seen that this method requires in a marked degree confinement to bed and slow healing.

Dr. Banks, of Liverpool, has practiced a method in most of its details like that which I shall describe to you, and has reported fifty-two cases of medium sized non-strangulated hernias with two deaths, sixteen large non-strangulated hernias with four deaths, and thirty-eight cases of strangulated hernia in which the operation for radical cure was combined with that for the relief of strangulation, with three deaths. It will be seen that in sixty-eight non-strangulated cases he has had six deaths, a proportion unusually large, which seems almost inexcusable. Out of sixty-six reported cases he has had fourteen failures.

There are other methods, as is well known, Spanton's for example, but they are practiced so sparingly, or else have such evident faults that I do not think it worth while to consider them here. Permit me now to describe a proceedure which I have practiced frequently and to which I have held fast, induced thereto by the results of a somewhat extensive experience. Supposing first a case of non-strangulated hernia in which we go to work deliberately for the purpose of effecting a radical cure; time, place and surroundings being at the disposition of the operator. The patient is prepared as for any serious operation. After careful shaving and washing of the parts, incision is made over the inguinal canal and external ring, extended as much further downward in either sex as may be desirable. The hernia is at once exposed and search is made for its proper sac; sometimes this is easily found, especially when the hernia is old and large; at other times it may be so incorporated with the spermatic cord as to require a careful search. If the case be not one of congenital origin the sac is carefully isolated and separated from all its surroundings. It is often an advantage, for the purpose of security, to split up the inguinal canal to aid in this search and separation. It is my habit to usually open the sac; if it be found empty there is nothing to do but to ligate its neck as closely as possible to the internal ring. This ligation is made with a carefully prepared catgut strand; if on the other hand, there be found adherent intestine it is carefully detached and restored to the abdominal cavity. If adherent omentum be found, I usually slit up the sac so that a ligature may be thrown around the omental mass high up the sac. It is then ligated efficiently, the part outside the ligature divided, the catgut cut short and the omental stump dropped into the peritoneal cavity. The adherent portion remaining is then removed with the extirpated sac.

If, however, we have to deal with a congenital hernia in the male, the sac is separated well down toward the testicle and a second ligature is thrown around it close to that body. By this proceedure a shut serous sac is provided which shall hereafter do duty solely as a tunica vaginalis testis. The portion of sac intervening between the two ligatures is then extirpated.

In a case of inguinal hernia in the female the endeavor is made to isolate and extirpate the entire sac, following it into or drawing it out from the labium majus as necessary. The balance of the operation consists merely in the introduction of from two to four silver wire sutures between the columns of the ring and the divided edges of the inguinal canal, by which the parts are brought into close approximation. The sutures are twisted, cut short, their ends turned over and left in such shape that no sharp ends of wire can press into or interfere with the surrounding parts. The integument is then closed over this wound with catgut sutures. If now the operation has been antiseptically performed I have found in every instance perfect immediate union within forty-eight hours, without necessity for drainage. I have been led to the use of silver wire by experience. At first I followed Czerny's recommendation and closed the external ring with a shoe-lace suture of catgut threaded upon two needles. Distrusting the permanency of catgut I then used interrupted sutures of silk and kept up this practice until in one of my cases two of the silk sutures were extruded through a minute sinus. The protection seemed perfect, but I did not like to have my sutures thus passed out. Ever since then I have used small silver wire, carefully cleansed before using, and have never known irritation to follow its use nor anything undesirable to attend the same.

The method as above described has to be somewhat modified in the case of femoral hernia. Here one may isolate the sac, return or remove its contents as already described, and ligate its neck, twisting it or not as he may prefer; but he will not find such a complete and accessible canal to deal with as in the case of inguinal hernia, nor any such ring to close. It will be but seldom in these cases that silver wire can be used to any advantage; nevertheless if the sac has been properly disposed of the wound will be filled by a cicatricial plug and the relief will be almost if not quite as perfect.

Upon umbilical hernia one may follow precisely the same general method, only modified as required by the surgical anatomy of the parts. Umbilical herniæ in adults are most commonly found in women with pendulous and very thick, fatty, abdominal walls. In such cases while there seems to be but little external evidence of a hernial mass there may yet be found a sac the size of an orange, and I have more than once been surprised to find how small the opening into this sac really was. Opportunity for strangulation is increased rather than diminished by so small a ring, and it seems to me that these cases require radical relief fully as much as any others. In several of these cases I have cut down upon the sac, which is usually, at the location of the navel, closely adherent to the skin, have separated it from all its fatty and muscular surroundings, have opened it and restored its contents according as they were intestine or omentum, have thoroughly extirpated it, have then brought together the margins of the umbilical ring, whether large or small, with catgut, and have then sewed up the abdominal wound in two or three tiers with silver or silk sutures, and have never seen the slightest disturbance follow. I have operated upon an infant but recently weaned, with rapid recovery; also upon a woman four months pregnant, of which fact I was not cognizant at the time, without the slightest disturbance or apparent tendency to miscarriage. One remarkable case met with in this city, which I propose at some time to report in detail, occurred in a woman weighing 280 pounds, presenting a large umbilical hernia whose sac outside the body was nearly as large as her head, and so pendulous that when she assumed a sitting posture its lower margin touched the chair before her buttocks did, and which presented in its thickness fibro-sarcomatous masses that were already ulcerating externally and were giving rise to great disturbance. I opened the sac, replaced its contents and extirpated the balance of the whole mass, without her temperature ever reaching 100°, and sent her to her home on the twelfth day following the operation. This shows what may be done even in such aggravated cases. At first I used to require my patients to wear a truss for a few months after the operation; at present, unless the circumstances demand it, I advise the contrary, agreeing with Mr. Kendal Franks that the pressure of the hernial pad is more likely to cause absorption of the cicatricial tissue that constitutes a barrier to the return of the hernia, and that it may be an instrument for harm rather than for good. I have moreover systematically added to my operations for relief of *strangulated* hernia the proceedure above described, by which I endeavor to secure a radical cure — if possible — in every case. It adds an almost inappreciable element of danger while it very materially enhances the benefit of the operation.

I do not wish to detain you longer and will content myself now with presenting a brief resume of my personal work in this direction. For the sake of convenience as well as of accuracy I have divided my cases into two classes, one class comprising cases of active and serious strangulation, in which to the operation for immediate relief I have superadded that for radical cure; the other class comprising cases upon which I have deliberately operated at a time when no immediate or urgent symptoms required it. Of cases of the first class I have had twenty, the oldest seventy-eight and the youngest six years. Eleven of these have been males, and five females; four of these have died but from causes in no wise connected with the operation, unless the possible element of shock should be taken into consideration. The four were cases of desperate nature in old or decrepit individuals, from whom scarcely anything else could have been expected. I believe that the first of this series of cases in which I operated had a partial return of his hernia but I understand that he is now going about as usual, not wearing any truss and not suffering from any hernial protrusion that one can detect.

Of cases of the second class I report *fifty, not only without a death, but without the occurrence of any sign or symptom which has at any time given occasion for alarm.* Most of these cases have pursued a course as even and undisturbed as follows the slightest operation after an anæsthetic. Only once or twice has suppuration occurred, except where a line of granulations might follow the external wound for the distance of a fraction of an inch. Fifteen of these have been in females, and of these fifteen, six were umbilical and two femoral. Of the thirty-five male cases the hernia was in every instance of the inguinal variety. Of the entire number six have been cases of double hernia, operated upon at the same time on each side. I have no hesitation in operating upon both sides synchronously if the condition of the patient justified operation at all. In one enormously fleshy, elderly man I have made this operation with, if possible, less disturbance than I have seen following a single operation. A few of my cases are in the West, a fair proportion of them live at a considerable distance and perhaps half of them are residents of this city or county.

It is fair to suppose that if the condition had returned in any of them I should have had some intimation thereof. Of all the cases that have come under my personal observation, I can say that not in a single one has there been any return, nor has any occurred to the best of my knowledge in any of the others. I can, therefore, claim that to the best of my knowledge and belief I have made a complete and final cure in every one of these cases. Many of them are pursuing trades or occupations which lead to excessive labor or strain, and it seems to me that the test of final cure in many of them has been as rigid as it ever can be. I desire to conclude simply with the statement, that according to the best light that we have, it appears to me that the common forms of hernia can be now absolutely and permanently relieved with so small an element of danger that it seems as if every person otherwise reasonably healthy could be properly encouraged to undergo the operation; while even a failure, should one result, leaves the patient no worse than before; while the vast majority, if not all of these sufferers, will obtain an ample reward for the trifling danger which they have undergone.

NOTE.— Since writing most of the above I have attacked an enormous scrotal hernia in an unfavorable subject, at his special request. His case properly belongs in my first class of cases (and is there included in the number of fatal cases), since he had had a very recent attack of strangulation, the second of its kind. I met with great difficulty in the reduction of the hernial mass, and during efforts at reposition the intestine (colon) ruptured in two places, at points where there had evidently been previous ulcerative or necrotic processes. The intestinal rents were sutured, and before death he had several normal evacuations from the bowels. Autopsy was not permitted. No clinical signs of peritonitis were met with, and death was caused in large measure by cardiac disturbance.

THE ETIOLOGY AND TREATMENT OF CERTAIN FRACTURES OF THE UPPER EXTREMITY.

BY E. M. MOORE, M. D., ROCHESTER, N. Y.

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[An address delivered before the Central New York Medical Association, November 20, 1888.]

When I was informed by Dr. Bailey that, at the twenty-first anniversary of the Central New York Medical Society, my address was to sound the note of the special topic of discussion of the day, the announcement was received by me with great personal gratification. We all desire the good opinion of our fellows, and as time wears on and the hair whitens, the good opinion of those who follow us in the paths of usefulness seems especially pleasant. It is a great thing to be able honestly to believe that one has not lived in vain. It has been said that any one who has added one new thought to the general stock of the knowledge of mankind which has passed into human thought as something new and individual, has not lived in vain though he has added one and only one such thought. Now at this time and under such circumstances I shall lay aside my usual modesty. In fact, I have been invited to become egotistical. We can hardly advance views which differ from those of our contemporaries, and press such opinions upon the members of the profession without being egotistical.

It was in the year 1839, just as it was closing upon a bitter, cold day, that I first came to the city of Rochester, so that it may be said that my professional life commenced in 1840. It will soon be fifty years since then — a good long time — and from that time, yes, and even before that time, I made up my mind to be a teacher in the profession which I had adopted and loved. In 1841 I began my first teaching in this town. One of my pupils then is with us to-day, Dr. Green of Homer. I had a class of eleven young men. I taught anatomy, as most of you know, from 1843 to 1883. I was a teacher of surgery in one institution or another. This long continued association with the best minds in the profession in the United States should not be barren of results, and when I am to select some portion of this experience to embody in a paper of this kind, it is a matter of some little difficulty to know how to circumscribe it. I had an opportunity to devote much study to other portions of the human body besides the arm, but when it was suggested to me to draw up this paper, I decided to confine myself to this subject. Therefore, without any further talk about myself, without any further egotism, I will begin by giving a little description of the treatment of the fracture and dislocation of the clavicle. My views are not the result of observation and my conclusions have not been arrived at by such methods as usually influence the formation of opinion. They are formed purely upon a brain baby. While musing I have caught the tip end of the thought, as it were. It is a recognized fact that the methods of treating the fractured clavicle have not in times past been quite adequate to the occasion. This led me to study the rationale of the methods of treating the fractured bone and as a result of this study I came to the conclusion that these methods contained in themselves the causes of failure. Professor Park was in the habit of seizing the patient by the arm while illustrating the treatment of the fracture to his class and drawing the limb backward. This reduced the fracture. But he would say, "If you want to know how you can complete the cure after having reduced the fracture so effectually, the only way I can suggest is to stand and hold the arm there until the bone has united." The result of my investigations along this line have resulted in the conclusion that the solution of the problem lies in a method which is as simple as all of the best and surest methods are. It is well known that the treatment of this fracture is conducted generally upon two plans with a great variety of modifications of detail. One is by the use of the axillary pad which is the fulcrum for the humeral lever; the other is by the figure eight bandage which draws the shoulders backward by passing around the axilla. There are other plans, but these prevail. I regard the treatment of the clavicular fibres of the great pectoral as the key to the solution of the difficulty that has thus far hung around this fracture. There are other considerations, however, among the principal of which is the position of the scapula. When we place a patient in a chair and, standing behind him, seize the upper part of the arms near the shoulder and draw them backward, the replacement of the fractured ends becomes perfect almost with certainty. But when, with more force, we use the axillary pad or figure of eight bandage, the restoration is so rare that many surgeons assert its impossibility. I criticise the axillary pad for the relaxation of the clavicular fibres of the great pectoral. If this results from its action we lose the antagonist of the sterno-cleido-mastoid, and therefore, no matter how high we elevate the shoulder, the end of the inner fragment will be higher. But if the shoulder is carried backward and the clavical fibres of the pectoral muscle are rendered tense, the riding of the inner fragment will be brought down, thus securing perfect apposition. This results from the well known treatment by recumbent posture and from the attitude in the chair, as above described.

The attachment of the great pectoral to the humerus, it will be remembered, is quite peculiar. The muscle makes a half turn upon itself, and is inserted for a full inch and a half along the bicipital groove, the thoracic fibres running to its upper and the clavicular to its lower part. It must be obvious that the tension of the fibres in the same muscle must vary according to the position of the humerus. If the arm is carried backward it moves from the shoulder as the fulcrum, the lower portion of the muscular insertion describing the larger circle, thus involving a greater tension of the clavicular fibres. By this tension we antagonize the sterno-cleido-mastoid, and if the shoulder be carried back far enough, the opposition will be perfect, provided no inequality of the fractured surfaces prevents, which will often happen in oblique fractures even when the full length is fully obtained.

Before presenting a plan of treatment I will criticise in the first place the axillary pad. As the large end of this pad is placed upward it operates, of course, upon the humerus just at the border of the axilla. Its rationale is that of a fulcrum for the humerus as a lever. The motion on the fulcrum, if a line, is nil. The pad is opposite the attachment of the clavicular fibres of the pectoral muscle. At the point of their insertion there is no motion, no matter how much force we may use. The shoulder is thrown out as far as the pectoral muscle will allow. The upper end of the bicipital groove is the point of insertion of the muscle that is put on a stretch, because it is removed from the fulcrum. The clavicular muscles of the pectoral are relaxed and kept so, and the sterno-cleido-mastoid draws up the inner fragment.

I also criticise the figure of eight bandage for producing a similar relation of the clavicular fibres of the pectoral muscle. This bandage acts upon the lower border of the muscle, and the more tightly it is drawn, the more it will curve its axillary border, and incidentally shorten it. The fibres of the clavicular muscles are not bent and, of course, not shortened. Thus they are inevitably released by the drawing in of the humerus. It will thus be seen that in the effort to carry the shoulder out by the axillary pad or backward by the figure eight bandage, the condition of tension of the thoracic, and relaxation of the clavicular fibres of the pectoral muscle results. The indication therefore to be fulfilled, is to reverse the action and, by carrying the humerus backward, make tense the clavicular and relax the thoracic fibers of the pectoralis major muscle. This motion is at the shoulder joint as a pivot. The tension of the pectoral fibres is now reversed. The lower portion of the bicipital groove is moved through a greater circle than the upper, and the clavicular fibres are rendered tense in proportion to the distance the humerous is carried back.

No plan that leaves the humerus perpendicular can make the clavicular fibres tense.

The scapula must also be moved as near the spine as can be borne, for the obvious reason that the thorax is the most salient portion of this part, and a sliding of the scapula thus produces the greatest movement of the shoulder backward, one of the most natural indications. As it goes backward it also goes up. I also make criticism upon the effect of the shawl, Fox's or Dessault's bandage, in its operation on the scapula. If the hand be placed upon the inferior angle of the scapula and the shoulder raised, keeping the humerus perpendicular, it will be seen that the scapula moves forward upon the thorax at its lower border. This criticism, however, does not obtain with reference to the figure of eight bandage. This is in the wrong direction, and although it is the lower angle it nevertheless allows the whole scapula to come forward, and thus shorten the broken clavicle.

The obvious indications in the treatment of this fracture, therefore, consist in the use of any bandage or posture that will carry the humerus backward and hold it toward the side. The effect of carrying the arm backward is to move the scapula toward the spine, thus fulfilling the most important indication. But, beside this, as before stated, the clavicular fibres are rendered tense by this attitude and thus the only remaining indication is fulfilled. Some aid, perhaps, may be obtained by lifting the shoulder from the elbow, but this is subordinate. In order to obtain the result stated, I have resorted to various devices. I use a shawl or cotton cloth which, (eight inches in breadth at the center), should be about two yards long. Placing this at the center across the palm of the surgeon, he seizes with his hand the elbow of the patient which corresponds with the broken clavicle. The two ends of the bandage hang toward the floor. The one falling inward toward the patient is carried upward in front of the shoulder and over the back, making a spiral movement in front of the shoulder. This is intrusted to an assistant. The outer end is then carried across the forearm, behind the back, over the opposite shoulder and around the axilla. This meets the other end which may be carried under the axilla and over the shoulder of the opposite side thus making the figure of eight turn around the sound shoulder.

The forearm should be sustained by a sling which raises it to an acute angle in order that gravity may assist in moving the whole arm backward. Any tendency on the part of the shawl to slide from the shoulder, may be arrested by a pin thrust in at the crossing. The shawl at the elbow is kept in place by folding the upper part that fits the arm and securing it by a pin. This makes a sort of cup for the elbow. It will be observed that the shawl, as it passes in front of the arm, does not press upon the axillary border of the pectoral muscle, and, therefore, avoids the objection of the ordinary figure eight. It passes over the forearm and over the opposite shoulder; it lifts up the arm like the ordinary shawl bandage.

One day a stout, healthy laboring man, a typical case, came in with a fractured clavicle. I thought if I could continue to keep the arm back I should succeed in effecting a perfect cure. I threw it back and to my gratification the bones came neatly into place. I wound adhesive plaster around the man's body without regard to any rule until I had the arm fastened in the desired position. I did not follow Dr. Sayre's rule. I regard his plan as incorrect because it makes the arm a lever. I watched this case carefully and was convinced by the result that I was secure in my theoretical position. Then I tried rollers. I used to practice on my boys evening after evening until they became tired of it, and the important question would be, "Whose turn is it to-night?" The art of surgery is to apply such means as are usually at hand. I have often told my students that they should be able to reduce and dress fractures if they were alone with the patient in the woods with no instrument except a jackknife and with no appliances excepting withes and leaves.

(At this point Dr Moore called a young man from the audience and assisted by Dr. R. M. Moore he demonstrated his method of applying the figure eight bandage. A roller under the arm carried up and pinned to the bandage at the shoulder aids in keeping the arm steady and holding it in position.) He continued: If we fulfill the two conditions of carrying the arm up and back the third will follow. Patients often complain of intense pain in the opposite shoulder. I advise them to lie flat on the back and extend the opposite arm and this always affords relief. A young carpenter told me one day that he had an improvement in the shape of a piece of tin, beat into the shape of a crutch which would support the bandage. I did not adopt his suggestion, but I have sometimes drawn the bandage through rubber pipe. In experimenting I found that by drawing the arm back it will force the scapula an inch or an inch and a half towards the spine; that will give the clavicle its full length. You may ascertain this by measuring it after the fracture has been reduced, and yet there may be a slight projection which, when the inflammation has subsided, will not produce a shortening of the clavicle. The full length may be obtained by tightening the bandage daily for a week or ten days. After that time the patient can move his arm without danger of stretching the bandage.

I knew this theory to be correct and resolved to apply it to dislocation of the clavicle. Dislocations, treated by the common methods, are approximated and there is no instance on record of a perfect cure of this sort of injury unless the patient was kept in a recumbent position during the treatment. A lady very anxious to be cured without deformity, would submit to this treatment. Dr. Sherman, of Ogdensburg, told me that he had a case, the first in thirty-five years of practice. He went to the books and could find nothing except the regular apparatus. He tried them and they did not answer. He then applied my bandage and the patient was instantly relieved of the intense pain and a perfect cure was the result. He had another case, a drover who had been knocked down by an unruly animal. He used my bandage and the bone was easily carried into place and the patient recovered with a full length clavicle. The patient went to Boston with the bandage on and came back all right. A physician in this city, Dr. Montgomery, had a patient who had dislocated his clavicle. The patient was a blacksmith, and his strong right arm was injured. He tried various appliances and they failed. He then tried the bandage with such perfect success that a careful examination could not show that a dislocation had occurred. Another case was, after recovery, brought before the County Medical Society, and it could not be told on which side the dislocation had taken place. I am privileged to be egotistical, and I believe that I not only invented a plan by which a fractured clavicle can be reduced without shortening, but also one by which dislocations of the clavicle are reduced without leaving any evidence of injury. I am speaking to many of my old students who have heard me on this subject before, and they will appreciate my position.

(TO BE CONCLUDED.)

SOME OF THE MORE RECENT ANTI-BLENORRHAGIC REMEDIES.

BY ERNEST FINGER,
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[Translated, at the author's request, for THE MEDICAL PRESS, by Dr. Ernest Wende.]

The abundant medicinal treatises stored up in the special therapy of blenorrhœa, have recently acquired several valuable additions which deserve more than passing notice. Within the past decade the teachings regarding gonorrhœa have vastly changed. Its pathology has received the necessary attention. Freed from narrow and constricting influence it has been placed upon a scientific basis. In its etiology progress of a most essential character has been made. From an etiological point of view, with the recognition of the gonococcus as the true virus of blenorrhœa, we have attained the object of our endeavors and study. Therapy has been promoted by rendering greater accuracy possible in following indications through the advances made in pathology, the more exact appreciation of symptomatology, and the localization of the urethral blenorrhœa, while etiology has brought no corresponding change or advance in therapeutics. It is true we can at present demonstrate the virus, isolate it, cultivate it, and study its nature outside the human organism, but the existence afforded the gonococcus upon any of our available nourishing media is poor, easily disturbed, and precarious. It is destroyed on the slightest attack while we are unable to successfully assault it on the mucous membrane of the urethra—its stronghold. We have found no remedy for its destruction, nor can we hinder its growth without injury to the mucous membrane itself. Under the existing circumstances, all hope is well-nigh abandoned of ever acquiring a drug that will put an end to the gonococcus without detriment to the cells of the urethral lining, since the virus of blenorrhœa is likewise cellular and proto-plasmic.

Therefore, in the treatment of gonorrhœa we are still dependent on the empirical for the selection of remedies. Thus far the medicaments employed have chiefly, yes exclusively, as Record and Roquette have shown, a local action. This applies not only to those remedial agents used topically, as injections, but also to those which take the round about course through the alimentary canal, blood, kidneys, and are finally dissolved in the urine. The balsams are examples of this class. The balsam of copaiba may be cited as a representative of the group. It is a drug of great value, but secondary results are frequently produced in the intestines or on the skin often preventing its further use.

Recently we experimented with two members of this group which are equal to copaiba in virtue and free from its unpleasant effects. Therefore they are most welcome substitutes. As one we may mention the oil of sandal-wood, produced by the distillation of the syrium myrtifolium. Henderson and Panas, as early as 1865, recommended it as an anti-blenorrhagic. In France it had been prescribed repeatedly, among others by Nirgon and Pathault. In Austria and Germany it remained in obscurity until lately, when Posner, Meyer, Letzel and Linhardt directed their attention to this valuable remedy which is similar to capaiba in its results on blenorrhœa, yet without its secondary complications.

Numerous experiments made with specimens kindly procured for me by Dr. Gutt, provisor of the Engelapotheke, taught me the effect and value of sandal-wood. I first employed it among the out-door patients of the poor department of the "K. K. Allgemeinen Krankenhaus," and then in my private practice. I found it decidedly preferable to copaiba. It should be dispened in capsules, taken soon after each meal owing to its disagreeable taste. I am convinced when administered in this manner, digested with the food, all undesirable result, and secondary symptoms will be avoided. I prescribe

Olei santal rubri, ... 0.2 — 0.5.
Da ad caps. gelatin.

Exhibe tal. dos. xx.
Sig.: 4 — 6 daily.

If possible two capsules should be taken after each meal.

The second remedy equally valuable is Kava-Kava, the root of the piper methysticum. Dupouy, who first made known its anti-blenorrhagic properties, makes a decoction of the root. He uses 5.0 cut into small bits, digested in 1,000.0 of water and filtered. The resulting fluid has a grayish color, and an aromatic taste.

Blackerby recommends:

Fl. ext. Kava-Kava,	100.00.
Spts. aether nitros,	35.00.
Syr. simplicis,	70.00.

M. Sig.: Three tablespoonsful daily.

Schutt prescribes:

Fl. ext. Kava-Kava,	15.00.
Ext. rhus. aromat,	8.00.
Bals. copaibæ,	15.00,
Tr. cubebæ,	60.00.

M. Sig.: Four teaspoonsful daily.

After many experiments with the fluid extract of Kava-Kava procured from Dr. Gutt, which had a dark brown color and an absinthian taste, I found that the simplest way of administering it was without any further additional remedies. I prescribe it in 15-30 drop doses in water after meals. The taste is not unpleasant. All troublesome and undesirable secondary results are wanting, particularly gastric disturbances. On the contrary it seems to stimulate digestion and regulates the bowels.

The indication for the administration of oil of sandal-wood or Kava-Kava are identical with and on the whole correspond to those of balsam of copaiba.

We recommend either remedy, where we have to deal with an acute blenorrhagic process, the acuteness of which prohibits the intense action of astringents, but in which we consider a mild topical action allowable.

1st. In acute urethritis anterior. During the first two or three weeks of a recent gonorrhœa as long as the discharge is profuse and of a greenish-yellow color, when micturition and erections are painful, contra-indicating the employment of injections.

2nd. In acute urethritis posterior.

3rd. In acute urethrocystitis posterior.

With regard to the pathology, symptoms, and diagnosis of these forms, I must limit myself in this paper, but refer you to the extensive discussion of the same in my work on "Blenorrhœa of the Sexual Organs and its Complications," published by Franz Deuticke, of Vienna, 1888.

In all three forms, the administration of either remedy is contra-indicated, should the process be exceedingly acute, for mild topical applications frequently cause an increase in the inflammatory process. A purely symptomatic treatment is urgently advised.

All balsams, among them sandal-wood and Kava-Kava are contra-indicated, in the early stages of the so-called phlegmonous gonorrhœa, in hæmaturia, in painful and frequent urination, in albuminous urine, in cases of urethritis posterior, in cases of alkaline or ammoniacal decomposing urine, and in cases of urethro-cystitis posterior with severe subjective symptoms. However, both remedies display a beautiful action within the bounds of their indications. They subdue the inflammation, lessen or allay the pain, also the ardor urinæ. They diminish the secretion, clear the urine and shorten the acute stage of the disease, thus facilitating the earlier use of energetic local astringent applications. Their action may be antiseptic and bacteriacidal. In favor of this theory is the fact that the urine of patients who have been taking these remedies, whose urine has the characteristic odor of violets, may stand exposed for a long time without decomposing, proving the urine to be a poor medium for the development of the well-known bacteria of fermentation.

The astringents employed in the local treatment of gonorrhœa are required to produce but a superficial and slightly astringent action, therefore, they can be used in dilute aqueous solutions.

But essentially different are the circumstances in the treatment of chronic blenorrhœa. Here the treatment should be more distinctly localized and more energetic. In this we endeavor to attain our own purpose by applying concentrated aqueous solutions with a brush through the endoscope, or we may use as a vehicle for the astringent some substance as gelatin or coco-batter, which melts at the temperature of the urethra. Even these vehicles have failed to confine the astringent action to the desired localities. These firmer substances upon melting spread over a greater extent of the mucous membrane, coming in contact with healthy parts of it. There is still another draw-back in that the aqueous solutions, as well as the gelatin and coco-batter, fail to adhere to the urethral mucous membrane. The astringent action ceases as soon as the vehicle is washed away, which invariably takes place at the first micturition. On the contrary lanoline is a vehicle which deserves a decided preference. It is the only one known to us which will cling to a mucous membrane. It is also readily absorbed by the same. Furthermore, according to the investigations of Gottstein, it has the additional and essential advantage of being aseptic and antiseptic, a circumstance which is of no little importance in the therapy of urethritis. Lanoline, therefore, commands itself a priori as the best vehicle for the application of astringents to the urethra.

Its use is further facilitated by Tommasoli, who constructed a syringe for the application of ointments to the urethra. It consists of a short catheter (no. 16 or 18 French) which has a moderately large opening at the vesical end. It contains a piston with a flexible shaft which is graduated to indicate decigrams of ointment. It is filled by means of an ordinary urethral syringe charged with the ointment. Its nozzle is introduced into the ointment syringe and the ointment forced into it.

The employment of this instrument for the purpose of applying lanoline is recommended in the treatment of chronic blenorrhœa. In recent cases lanoline ointment should be used alone. In old inveterate cases where sounds and urethrometers indicate thickening of the mucous membrane, the beginning of changes in the lumen of the urethra, sounds of a gradually increasing size should be passed, as recommended by Otis. A sound, annointed with lanoline ointment, should be introduced every second or third day, for about five or ten minutes. Small particles of the ointment are thereby left adhering to the diseased localities.

The following ointment is recommended for recent cases:

Argenti nitratis or cupri sulph.,	1.00--3.00.
Lanolini,	95.00.
Ol. olivæ,	5.00.

M. exactissime.

For moderate cases, ointments containing iodide of potassium and iodine are to be used.

Potass. iodidi,	5.00.
Iodini puri,	1.00--3.00.
Lanolini,	95.00.
Ol. olivæ,	5.00.

Misce exactissime.

And finally in recent cases I have employed, of late, creolin ointments with good results.

Creolini,	1.00 -- 3.00.
Lanolini,	95.00.
Ol. olivæ,	5.00.

Misce exactissime.

MERCURY CYANIDE IN DIPHTHERIA.—The Swedish physician Stellden reports on 1400 cases of diphtheria treated by him with mercury cyanide. There were, among that number, but 69 deaths—not amounting to five per cent.; while, ordinarily, in the same district, the death rate showed 92 per cent.

Stellden's formula is:

Mercury cyanide,	0.02 grammes	[0.3 grain].
Tincture aconite,	2.0 "	[30.0 "].
Honey,	50.0 "	[450.0 "].

Mix. Dose: One teaspoonful every 15, 30, or 60 minutes, according to patient's age.

Besides this, a gargle of 1 part mercury cyanide to 10,000 of peppermint water is to be used every 15 minutes.

These frequent doses and applications are supposed to create a medium in which the diphtherial bacillus cannot live.—*Merck's Bulletin.*

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BUFFALO, N. Y., FEBRUARY, 1889.

SURGICAL KIDNEY.

Surgical kidney is a somewhat vague and indefinite term applied to a condition, whose marked expression is found in the kidneys, quite commonly fatal, which may follow alike so trifling a proceedure as the introduction of a catheter or any of the most grave operations upon the genito-urinary organs, especially of the male. In speaking of surgical kidney proper, we should omit from the discussion all reference to metastatic pyæmic abscesses, tumors of the kidney, and in fact to any but inflammatory and consequent suppurative changes. Surgical kidney is always the consequence of any extension of irritation or inflammation from the genito urinary organs below. Dickinson says that of all renal disorders, next to the varieties of albuminuria, this is the soonest destructive to life. It may almost be said to form the natural termination of stricture of the urethra, and is the especial danger which attends the use of the catheter. In the words of another authority, it constitutes the most frequent termination of all urinary cases. The justification for the term "surgical" is simply the fact that the inflammatory changes comprised within the meaning of the word have been so frequently met with associated with conditions of the urinary passages requiring surgical operation. As Barker has made it out, this is an unfortunate misnomer, tending as it does on the one hand to suggest that the disease is met with especially as the result of operation, and on the other that it must necessarily follow surgical disorders or inflammatory changes in the organs below. Neither of these propositions is true. We do often meet with the condition independently of surgical operations, and operations on cases of great severity have frequently been made without being followed by renal mischief.

The pathology of the condition is about as follows: The organ may or may not be enlarged. In recent cases the capsule is easily removed except at certain points where firm adhesions may be met with. At these points the appearance of the cortex will be altered and it may range in color from purple to an ashen-gray. It the latter case the bleached area becomes softened, perhaps bulging externally, giving to the whole organ a peculiar irregular outline. On division of this area it will be found that each bulging portion corresponds to a suppurative tract reaching from the apex of a pyramid to the cortex, with frequent destruction of the entire pyramid. There will be found also evidences of pyelitis which will probably be seen to be an extension upward of trouble from the ureters and bladder. In other words we have to deal in these instances with a condition of pyelo-nephritis of varying degree of severity.

The somatic cause is commonly some obstruction to the flow of urine from the bladder, whether from stricture, enlarged prostate, tumors or calculus, which leads first to a chronic cystitis, commonly with concentric hypertrophy. Obstruction persisting long enough, it is followed by dilatation of the ureters and pelvis of the kidney, and extension of inflammatory suppurative changes, followed by a parenchymatous nephritis; the whole condition aggravated by decomposition of the urine and the introduction of septic ferments introduced either by unclean instruments or by extension from decomposing mucous and urine; or it may possibly occur as the result of renal calulus which has not yet passed or which cannot pass downward to the bladder and sets up, *in situ*, first inflammatory and later ulcerative changes. It may also be the result of tubercular deposits in the tissues or in the pelvis of the kidneys, but of all single causes the extension of old gonorrhœal trouble is certainly most frequent.

The symptoms of the trouble are usually severe pain through the loins, usually aggravated by pressure, accompanied by more or less febrile disturbance, hectic fever, perhaps, with its attendant signs and symptoms. There are present commonly a cachectic condition easily recognized, with hot, flushed skin, anxious expression and disturbed rest; and almost always a slight fullness may be felt in one or in both renal regions. The urine passed is usually deficient in amount and loaded with pus; if taken fresh from the kidney it is commonly acid, but if it has remained long in the bladder it will usually be found to undergo ammonical decomposition. After washing out the bladder and then collecting a little of the secretion, one can usually tell as to the true condition of urine as secreted by the kidney. Microscopically there are found besides pus cells and very numerous bacteria, mucus, blood, molecular detritus and kidney epithelium, and if the case be complicated with parenchymous nephritis we also find dark granulated casts from the straight tubules. The bacteria which are seen under the lens are often grouped together in zooglœa masses, shaped as cylinders, showing how rapidly they have reproduced in the tubules whose diameter and arrangement their masses assume. As the case grows more serious there will be added, to the symptoms above mentioned, chills and high fever, with the gradual assumption of the typhoid condition and utter prostration. Such a condition has sometimes seemed to supervene after a trifling operation, as the introduction of a catheter or sound; at other times it follows operation for stone, and in 1873, the Emperor Louis Napoleon died of surgical kidney following the operation for crushing the calculus.

Treatment of this condition is often most unsatisfactory. Nevertheless the disease is not absolutely hopeless. All sources of irritation in the passages below should be removed, obstruction should be relieved as completely as possible, with the least amount of violence and irritation. The loin may be cupped and fomented or blistered; the diet should be very light; tonics must be given, and in very asthenic cases may be combined with stimulants. Complete rest of body and mind are essential, and the patient's surroundings must be made as pleasant and as hygienic as possible. The bladder should be washed out with antiseptic and soothing injections. Benzoate of sodium may be given internally and will be indicated when urine undergoes ammoniacal degeneration. Medicines which are eliminated by the kidneys may be judiciously exhibited for the purpose of medicating the urine, making it less irritating. If the trouble can be located in one kidney, it may be quite proper to make an incision in the loin and cutting down upon it to treat it, as we would any other abscess cavity, by drainage and antiseptic irritation.

While prognosis is in these cases usually bad, it is possible to prolong life, sometimes almost indefinitely, and to make it endurable if not actually enjoyable. Of late years Dr. Willard Parker's suggestion has been more frequently carried out, and the bladder has been opened and drained either by perineal median section and continuous drainage, or, we may adopt Hunter McGuire's recent advice, and open and drain it by suprapubic section, with better prospects of securing a permanent and accessible opening which shall still be guarded by sphincter control. The case must then be in extremely bad condition which does not warrant our doing all we can and of holding out a prospect at least of temporary alleviation.

THE ADMINISTRATION OF THE IODIDES FOR DIAGNOSTIC PURPOSES.

In the *Therapeutic Gazette*, for December, 1888, appears an important and interesting discussion relating to the value of the "iodide test" from a diagnostic standpoint. Dr. J. William White opens the controversy by an effort to dispute the following statements made by H. C. Wood and Jullien: "In all cases of doubtful diagnosis the so-called therapeutic test should be employed, and if 60 grains of iodide of potassium per day fail to produce iodism, for all practical purposes the person may be considered to be a syphilitic;" and, "The existence of syphilis contributes powerfully towards producing tolerance of the iodides. Experience proves, in fact, that in persons free from this poison the toxic phenomena of iodism are much more to be dreaded. In the same manner an antidote may be dangerous or even fatal, when the organism is not under the influence of the poison which it is intended to combat." Jullien after calling attention to the fact that the rule may be of great value if true, or exceedingly dangerous if unfounded, the writer relates carefully the evidences of iodism and considers the causative morbid changes. The potent factor idiosyncrasy is closely examined and a weight of authority adduced to show its powerful influence as a sole or contributing agent in the production of iodism. Three cases are narrated to prove the tolerance of iodides before the acquirement of syphilis and intolerance during the tertiary manifestations.

Dr. White's main points in the argument may be succinctly stated as follows:

In certain cases of syphilis the iodides are not tolerated in any dose.

In a large proportion of syphilitics, iodism is manifest at some time during treatment.

That iodism depends almost entirely upon idiosyncrasy and that this certainly is a more active agent than the size of the dose.

That evidence corroborative of such statements and words, cannot be found by careful search and that most great syphilographers oppose them directly.

The article is closed by the following conclusions: I. "Personal idiosyncrasy is so strong a factor in relation to the toxic symptoms produced by the iodides, that it quite overshadows any possible influence due to the existence of syphilis." II. "There are no satisfactory theoretical grounds for believing that syphilis in any stage prevents the production of iodism by a process of neutralization, and this is particularly unlikely to be true as regards the later stages." III. "It is, therefore, most unsafe to base any diagnostic conclusion upon the presence or absence of toxic symptoms (iodism) after the administration of full doses of the iodides."

In his reply, Prof. Wood includes a long consideration of treatment. This portion of an unsatisfactory answer possesses rare merit, while it appears somewhat irrelevant. To quote his views in regard to an antagonism: "I believe that the actions of the two poisons are in some way antagonistically related; but this antagonism is not necessarily direct. It is not, to my thinking, probable that the drug directly antagonizes the syphilitic virus; it is more likely that the virus produces in the system changes, which secondary changes in turn alter the relation of the organism to the iodides." Objection is raised to the method of obtaining evidence on the ground that the question cannot be settled by a study of individual cases before and after syphilis is manifest, and the strongest reason for assuming a positive opinion is derived from clinical experience. That the writer is exceptionally well qualified to speak authoritatively no one will doubt, and the results of vast experience are cited to uphold the clinical fact as presented in this proposition: "Suppose it is found that out of a thousand cases of a disease which we will call (A) nine hundred and ninety-five bear well enormous doses of a remedy which cannot be given at all to any five out of every thousand normal individuals." The fact that the syphilitic displays a marked tolerance, especially in the late manifestations, is dwelt upon at length and ably presented. In reviewing the two sides of an old and unsettled clinical question, only the main features have received attention. The points of disagreement will be noted to arouse inquiry into opinions widely accepted. The dangers of a radical view have long been obvious, and the safe course seems to be in the direction of reserved judgment rather than strong conviction. It is probable that the experienced will prefer to follow Wood's statement as a rule, with exceptions dependent upon manifold conditions unfortunately not expressed in the articles mentioned. As a law it must be misleading and is not wholly scientific. It should be admitted, however; that the learned author does not neglect to modify the original assertion and refers later to the test as "evidence" not "proof," and affirms "that the fewness of opportunities would make it practically impossible to eliminate the overwhelming and predominant influence of idiosyncrasy." Admitting that as a factor which may exert its power to produce tolerance in the uncontaminated, or intolerance in the afflicted, the question should not rest there. Careful study of dose, mode of administration, absorption, elimination, and constitutional condition often dispel this enigma and restrict its mysterious influence.

If an unexpected result is to be explained as a diagnostic sign or an evidence of an idiosyncrasy, conclusions are apt to be ill-defined or valueless. The tend of such reasoning has been to give unwarranted meaning to the term "specific," and the failure to secure benefit by the adminstration of iodides too often leads to the belief that the diagnosis syphilis is erroneous. That the iodides are not only intolerable but predjudicial in syphilitis, when other measures secure relief, has deep signifigance in relation to this subject and it is to be hoped that a renewal of the welcome dispute will serve to extend its scope. With a view to obtaining diverse opinion the editor calls for answers to the following questions:

Query first. Has your experience with the use of iodides in syphilis been large, and in what stage of the disease have you seen most of your cases?

Query second. Have you noted any difference in the relation of syphilitis to iodides in different stages of the disease?

Query third. In your opinion, is, or is not the relation of the human organism to the iodides changed by syphilis?

Inasmuch as the subject is of great importance, attention will be directed to it in a future issue by further consideration.

THE OPERATIVE TREATMENT OF THE HYPERTROPHIED PROSTATE.

There has just been issued from the press of Cupples & Hurd, of Boston, a monograph by Dr. Watson, with the above title, which was presented at the last meeting of the American Association of Genito-Urinary Surgeons. It is in quarto form and is embellished by forty-four beautiful photogravure reproductions and a number of wood-cuts, and constitutes, by all means, the most notable contribution to this subject that has ever been made. While advising all who are interested in this subject to carefully study the work, we desire here only to review a small portion of its subject matter.

For serious cases of hypertrophied prostate with consequent cystitis we have two methods of treatment, the palliative and the radical. The palliative consists in draining the bladder either through the perineum or over the pubes. Of radical operations there are nine which in recent or more ancient times have been suggested. First, division of the median enlargement by cutting instruments passed from the meatus, that is, urethral prostatotomy; second, removal of a part or the whole of the median enlargement by the same channel, urethral prostatectomy; third, the same operations done through an external perineal section; fourth; tunnelling the median enlargement through an external perineal section; fifth, suprapubic cystotomy and removal through this rout of the median enlargement, suprapubic prostatectomy; sixth, division of the median enlargement by galvano-cautery through the urethra from the meatus. Three other methods have been suggested only by one or two men; these are injections of iodine into the substance of the gland, superficial cauterization of the deep prostatic urethra by galvanic action, and electrolysis by needles in the substance of the gland. To these last three methods the author pays no attention.

As indications for operation he refers to repeated attacks of retention, especially when the patient is not within reach of careful treatment, inability to urinate spontaneously, when attended by frequent painful or difficult or impossible catheterization (and this especially when there is also present a purulent or hæmorrhagic cystitis) and, in general, the failure of palliative treatment to alleviate such symptoms. With regard to choice of operations, there are three points upon which hangs the decision for one or another method. First, what Dr. Watson calls the perineal distance, that is, the distance from the junction of the membranous and prostatic urethra to the most distant point of the median enlargement within the bladder. If this be not above three inches the median enlargement can be reached by the finger passed through a perineal section, and effectually operated upon through this channel. Second, the form of the median enlargement; if this be pedunculated the suprapubic method will generally become that of choice. Third, the small capacity and non-distensibility of the bladder in any given case, or the reverse condition, for only under the latter condition can we perform the suprapubic operation with its modern technique.

The photographic plates to which we have just referred are beautiful pictures of morbid specimens with measurements, and a commentary upon each calling attention to just what might have been done in each instance and inculcating valuable lessons with regard to treatment of future cases. The author's conclusions deserve to be emphasized: First, that the evidence before us is sufficient in quantity, and sufficiently favorable, to not only justify but to demand operative interference under the conditions already laid down. This granted, the choice of operations lies first between the palliative method and the radical. If the patient's condition is one of such exhaustion as to make the radical operation probably fatal, a palliative operation should be done rather than to do nothing, since thus the patient's condition may be so improved as to allow of more radical measures later. In such cases drainage through the perineum is ordinarily the best; with this exception the radical operations may be preferred at the outset. It has been shown that they are not more dangerous and that, if successful, they accomplish far more. The objection to operation from the meatus is that it is applicable to only a limited number of cases, in which the condition of a bar between the lateral lobes or a very small median enlargement is presented; then only when its nature has been accurately made out beforehand, a difficult matter; moreover, such operations do not secure that free drainage after operation, which is a most important element. Their advantages over the perineal method are not apparent and they may, therefore, be set aside. This narrows the operative methods to the perineal and suprapubic methods. We see that every variety of the disease likely to be encountered can be reached and successfully treated by one or the other of these two methods. Anatomically two-thirds of all these cases are operable through the perineum; clinically the perineal operations are the safest. Positive indications from these facts are: In a given case open the membranous urethra and explore with the finger; two out of three times the operation can be completed by this route; in the other third of the cases the long perineal distance or the form of the median enlargment will make the suprapubic operation necessary. When this is the case, and if at the same time the bladder can be distended so as to allow of the operation being done with its modern technique, proceed to do it at once or later, according to the patient's condition.

The conclusions of Dr. Watson's will commend themselves especially to those who have already had experience with the surgical and operative treatment of these cases, while all of its readers must agree in the statement that Dr. Watson's monograph has shed a great deal of light upon a difficult subject.

AN INTERESTING MEDICO-LEGAL DECISION.

A medico-legal decision of no small interest has just been rendered in a case in Philadelphia. In this case the consultant, who was also the ordinary medical attendant, was absent from town; his advice was given by letter. After the death of the patient he rendered the bill which was contested, it being objected against the claim for compensation that the consultant could not show contract with the patient who did not personally summon him, nor was he called by a relative acting for the patient. The Orphan's Court, however, affirmed the contrary on the ground of public policy and awarded the claim. To further demonstrate the right of the attending physician under such circumstances to summon counsel if he deemed it desirable, the court said among other things, that the spirit in which this rule is to be expounded should be in unison with the character and relations which the parties have themselves established with each other, and should be honored just in proportion as those relations become more intimate and involve delicate questions of liberty and responsibility. To say that the discretion to act promptly in an emergency, which a patient necessarlly gives to his physician, is larger than that which a merchant gives to his drayman, is simply to say that a man will resign more of his authority to the will of a person who is to save his life than to a person who is to take care of his trunks. The trust, which includes the power of its exercise, with which the patient vests his physician is practically unlimited because it may require to be executed at a time when disease has taken away all ability to restrict. The patient is not to be left to die, on the plea that during such an interval no act of his adviser can be valid for want of direct approval. Or the doctor may suspect the presence of an obscure disease which if it exists demands heroic treatment; to communicate the suspicion to the sick man would probably finish him on the spot, may he not solve the doubt by consulting a specialist? The doctrine, however, on which the claim to be adjudicated has been repeatedly enforced is the doctrine of public policy. In its application the courts have held that a patient who leaves his child in the care of a servant will be liable to the surgeon who dresses the wound received by the child, although the surgeon was called by the servant and although the injury was caused by the servant's neglect.

We congratulate Dr. Hunt, the gentleman who gained the suit, and we gather the above facts from the *Medical News*, of December 15th.

THE *Canadian Practitioner*, published in Montreal, and hitherto conducted as a monthly journal, will hereafter appear as a semimonthly publication. Since we began exchanging with it, it has been several times enlarged and improved, and this further change will serve to conspiciously extend its scope and usefulness. It is certainly a thoroughly wide-awade journal and deserves all the success it may attain.

* * *

A NEW journal, *The American Practitioner*, is to be issued under the auspices of the Chicago Post Graduate Medical School. It is to be edited by Dr. Bayard Holmes, and will have all the faculty and demonstrators for collaborators. It will appear on the first of each month, and will be sold at one dollar a year. Chas Truax & Co. are the business agents and publishers of the new enterprise, to which we wish all success.

* * *

MESSRS. J. B. LIPPINCOTT COMPANY announce to the profession the publication of a "Cyclopædia of the Diseases of Children," medical and surgical, by American, British, and Canadian authors, edited by John M. Keating, M. D., in four imperial octavo volumes; to be sold by subscription only. The first volume will be issued early in April, and the subsequent volumes at short intervals.

A thorough knowledge of the diseases of children is a matter of the greatest importance to most physicians, and as this is the only work of the kind that has been published in English, it will be invaluable as a text-book and work of reference for the busy practitioner.

* * *

E. B. TREAT, Publisher, 771 Broadway, New York, will publish, early in 1889, the Seventh Annual Issue of the English "Medical Annual," a resume in dictionary form, of New Remedies and New Treatments that have come to the knowledge of the medical profession throughout the world during 1888. The editorial staff of the forthcoming volume, will include articles or departments edited by Sir Morrell Mackenzie, M. D., (Laryngology), London, Jonathan Hutchinson, Jr., M. D., (Genito-Urinary Diseases), London, J. W. Taylor, M. D., (Gynæcology), Birmingham, William Lang, M. D., (Ophthalmologist), of London, James R. Leaming, M. D., (Heart and Lung), New York, Charles L. Dana, M. D., (Neurologist), New York, H. D. Chapin, M. D., (Pediatrics), of New York, and others, comprising a list of twenty-three collaborators, widely known in Europe and America. In its enlarged and widened sphere it will take the name of "The International Medical Annual," and will be published in one octavo volume of about 600 pages at $2.75, under copyright protection, and issued simultaneously in London and New York.

He will also forward a copy of the "Don't Forget It Calendar," the best of its kind that we know of, to any physician who will send him six cents for its postage.

* * *

ONE phase of the medico-legal aspect of intubation is well illustrated by a case mentioned in a recent paper by Huber, of New York, (Arch. Ped., January, 1889). A child was intubed at the request of one of its attending physicians. It appeared to improve for some time. On the fourth day death occurred suddenly. The tube could not be found neither in the throat nor anywhere about the house. As it was known to have been in place only a few hours before, it was supposed to have been coughed up and swallowed. Dr. Horn, at whose request the tube was inserted, on the succeeding morning received the following letter:

"NEW YORK, February, 18, 1887.

"DR. JOHN HORN:

"*Dear Sir.*--In consaquence to death of the little childed by putting in the tube which I believe that the childed choked only throu that, I want you to take that out; I dont want to have that chiled berried with that tube. And if you dont take it out, I will be bond to make a complain to the Koroner against you. You must to take that out the same way as you putted it in.

"By doing so you will oblige Yours truly

"J. L.
"L. M. R."

Dr. Horn wisely referred the case at once to the coroner, who instituted the usual investigation. A minute search failed to find the tube. It was learned also that the tube had been coughed up, and when found had been melted, being supposed to be pure gold. And further that the child was allowed to sit up in a high chair at the table and had fallen upon its head. A convulsion supervened, immediately followed by death. The inquiry exonerated the doctor from all blame and promptly squelched the attempt at blackmail. It is not to be doubted that such complications will often arise as we have recourse to intubation, and the profession will do well to keep such possibilities, as the above, well in mind.

Correspondence.

LONDON LETTER.

London, Dec. 18, 1888.

Dear Doctor,—Through the courtesy of Mr. Keetly, I was invited to a meeting of the Royal Medical and Surgical Society, of London, an abstract of the proceedings of which may be of interest to you.

The papers read bore the following titles: "Primary Union after Excision of Tubercular Hip-joints." By Arthur E. Barker, F. R. C. S., Surgeon to University College Hospital, and "Primary Union after Excision of Tubercular Hip-joints." By Bilton Pollard.

Mr. Barker's paper had for its object the emphasizing of certain conclusions advanced in his Hunterian lectures at the Royal College of Surgeons last summer. They were as follows:

1. That scrofulous or, in other words, tubercular joint-disease is a local expression of infection of the tissues with the bacillus tuberculosis, and runs, as a rule, a course beginning in hyperplasia and ending in fatty degeneration.

2. That at a certain stage of the disease the complete removal of the infected tissues ought to be possible.

3. That if complete removal of the tubercular tissue from the hip be accomplished, the resulting wound ought to heal in many instances by first intention throughout, as in the case of the knee, and often even without the necessity for drainage.

The great advantages which would flow from such primary union are then briefly discussed. The author then describes his first case operated on after the above propositions were justified by the result. The patient was a boy, aged five years, who had been under careful treatment for a year for hip disease, which resulted in destruction of the head of the femur, and the formation of an abscess of the usual kind. After operation on the lines indicated, primary union took place without drainage under one dressing, and the patient left the hospital on the fourteenth day wearing a double Thomas splint. The latter was removed on the eighth week after operation, and the child went to the sea-side, when he began at once to run about, and has been quite well ever since.

Mr. Pollard's paper drew attention to the fact that the wounds necessary for the extirpation of tubercle from joints will heal as rapidly and as permanently as other wounds of a similar size if certain essential conditions be secured :

1. The whole of the tubercular growth must be removed.
2. Perfect asepsis must be assured.
3. Bleeding must be checked and the wound made as dry as possible.
4. Oozing must be checked by the even elastic support of a wool dressing and a moderately tight bandage.
5. Absolute rest of the part must be maintained during the process of healing.

The hip-joint is selected for illustration of the views advanced because the author thinks that, of all excised joints, the hip has been found the slowest to heal.

Four cases of advanced hip-joint disease with caseous abscesses are referred to. Three were operated upon by the anterior incision, and the fourth, by a curved incision round the upper and posterior part of the trochanter. Drainage tubes were not employed in any of the cases. The dressings were changed on the seventh day after the operation, and the wounds were found to have healed by first intention throughout. With the exception of one case, in which the acetabulum was perforated, there has been no recurrence of the disease. The above abstract I have taken from that printed for the use of the members of the society, and find that it gives the leading points in a small compass.

Mr. Barker's case was then exhibited and examined by various members. The child walked with a very pronounced limp and much wabbling of the joint, permitting free movement in various directions.

In the discussion following, Mr. Croft, of St. Thomas Hospital, first spoke, warmly commending the results of Mr. Barker and Mr. Pollard, and thought that such results marked a new era in this department of surgery. He then gave his own statistics in excision of the hip which, before 1880, was attended with failure in thirty per cent. of the cases, and since that year in fifteen per cent. (I say failure because of a misunderstanding of Mr. Croft by the members. Certainly he led everyone at first to suppose that the above figures referred to mortality in consequence of the operation. Upon being taken to task for such a record, he explained that he meant cases dying from tubercular disease subsequent to the operation). Mr. Bryant said in the first place that he did not agree with the author in calling the result a good one. In his opinion it was a poor one. He then said that expectant treatment was rather to be tried than surgical interference in all but advanced cases, and he seemed to think that Mr. Barker's case would have done better under the former plan. Again the early use of the limbs was to be wholly deprecated and for his part he would never think of removing splints until some months had passed by.

Mr. Hulke believed that the results of expectant treatment were preferable to those of excision. He thought that primary union could not occur in the deeper parts cf the wound, only in the superficial parts, and that it was impossible to excise the synovial membrane entirely through a small incision and, therefore, that recurrence was a probable affair.

Mr. Marsh thought primary union could take place, but that expectant treatment gave much better results in early disease than excision. In his experience the latter treatment was unsatisfactory. He strongly believed that the bad consequences of tubercular joints had been much exaggerated and that they required less radical surgical treatment than was generally believed.

Mr. Keetly said that primary union throughout could occur, and gave a case in point. Believed that expectant treatment often gave excellent results. He thought drainage tubes were unnecessary in antiseptically conducted wounds but that they added no danger and were, on the whole, an element of safety and ought not to be dispensed with. Furthermore, they are of especial use in cases where the antiseptic has had an irritant effect upon the tissues, and where all the disease had not been extirpated. They did not in any way retard nor prevent early convalescence.

Mr. Wright, of Manchester, who was present by invitation, had treated eight hundred cases in the last four years, among which occurred about one hundred and forty excisions. In his opinion the vast majority of cases taken in time and under good social circumstances were best treated expectantly and recovered without excision. He always uses the tube and never seeks for primary union. He thought section over the trochanter in no way superior to that through it. He thought that the disease could not be entirely removed in some cases at least, and unless the synovial membrane is wholly taken away the disease may easily recur. He kept on the Thomas splint from six months to a year, or longer as necessary.

Mr. Barker and Mr. Pollard replied to various questions asked them, and both impressed upon the society that the cases were by no means early ones as some had seemed to think but that in all cases the head of the femur was destroyed and suppuration had gone on to an advanced degree and that all other means had been tried. Mr. Barker in his case had not intended to leave off the splint so early, but this had been done by the parents during his abscence from London. He maintained his position upon the special points of his paper, after which the meeting closed. Very sincerely,

JOHN PARMENTER.

Society Proceedings.

BUFFALO MEDICAL AND SURGICAL ASSOCIATION.

REPORTED BY W. A. HODDICK, M. D., SEC'Y PRO TEM.

A postponed regular monthly meeting of this association was held Tuesday, January 8th, in the Mechanic's Institute Building; President P. W. Van Peyma in the chair. Dr. M. P. Cook was elected to membership.

Dr. Ernest Wende read a paper entitled "Favus," and exhibited several interesting photopraphs of cases, notably a picture of his own arm, on the surface of which he had inoculated favus from an eight generation pure culture. This paper was followed by one on "Surgery of the Knee-joint," by Dr. W. C. Phelps, which will appear in a future number of *The Medical Press.*

Discussion.— Dr. Mynter believes that Dr. Phelps lays too much stress on the removal of the articulating ends of the bones in strumous troubles of this joint. He believes that probably nine-tenths of these cases begin in a synovitis, in the rest as an ostitis. In the first class of cases the disease spreads over the surface but does not enter deeply if at all, while in the second the trouble is at first local, in the bone, extending slowly, and later involving the whole epiphysis. In the first it is a mistake to remove much bone, if any, while it is the correct thing in the second. In cases of gonorrhœal rheumatism he has excellent results by puncturing the affected joint, and syringing out the cavity with bichloride. The patient is then kept in bed for a week, the knee bandaged and given massage. Recovery follows in about two weeks.

Dr. Wetmore called attention to the variance of different authorities on the pathology of the knee-joint. Lister, according to Dr. Wetmore, says it is of great importance to operate early. Usually, it is then not necessary to do tenotomy for there will be little or no contraction. Dr. Wetmore operates, following Lister, by making a horizontal incision on each side of the patella into the joint, and scrapes out all diseased portions, using the finger as a guide, the leg is afterwards put on a posterior splint. He uses carbolic acid as the antiseptic.

Dr. Hartwig believes that Lister's operation is not a safe one, for one is very apt to miss tissues which should be removed. The incisions ought rather to be to planed, that sight as well as feeling can be used. He uses carbolic acid in cases of gonorrhœal rheumatism instead of bichloride as described by Dr. Mynter, and with success.

Dr. Phelps was in doubt as to exactly where the disease originates in tubercular troubles of the knee-joint, and was inclined to take a middle ground, neither asserting that the disease begins in the bone, nor in the synovia. At any rate, if the bone is involved such portions must, of course, be removed.

Under voluntary communications, Dr. Mynter reported a case somewhat as follows: Patient complained of great tenderness along the leg, over the fibula, with only a slight redness on surface, was drowsy, with temperature high, and pulse rapid. These symptoms came on very rapidly. Diagnosed acute infectious osteo-myelitis, anæsthetized patient, and split leg longitudinally down to the bone. The tissues were bathed in serum, particularly about the fibula, where a few drops of pus were found. Six hours afterward the patient's temperature was normal, and he was feeling much better. A complete recovery followed, and the wound granulated well. Dr. Mynter had seen but three cases before, and asked the members for their experience. Dr. Hartwig had seen a similar case of the tibia. The child died. Dr. Hoppens had met with two cases, and knew of a third, all children. In each of the first two, both fibula and tibia were involved. These patients also died within five days. Dr. Phelps had seen one case; the trouble seemed to date from a fall. This case was operated upon, other abscess followed. He also knew of a case which occurred at Leroy, where Dr Moore operated. The patient, however, died.

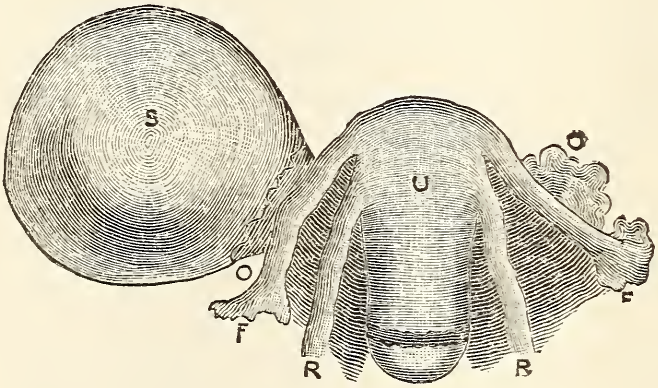
Prevailing diseases. Dr. Bartlett reports that there is considerable acute opathalmia about. Dr. Hubbell corroborated this statement and mentioned that many of the cases had a tendency to be purulent· The February meeting was postpond one week, occurring on the 12th instead of the 5th. The entire session will be devoted to the discussion of "Syphilis: Its Later Manifestations and its Curability." By Dr. C. G. Stockton: Medical, including Nervous; Dr. Roswell Park: Surgical; Dr. Wm. H. Heath: Genito-Urinary; Dr. Elmer G. Starr: Eye and Ear; Dr. F. H. Potter: Throat; Dr. Ernest Wende: Skin; and Dr. M. D. Mann: Heredity.

BUFFALO PATHOLOGICAL SOCIETY.

Regular meeting, December 21, 1888. The president, Dr. Park, in the chair.

The evening was mainly devoted to the discussion of "Ovarian Pregnancy."

Dr. M. D. Mann presented a specimen of ovarian pregnancy, and made the following remarks: An ectopic gestation having its seat in the ovary is so rare that some authorities are strongly inclined to doubt its existence. It is certainly true that many of the cases reported will not bear the test of careful criticism. This does not, however, apply to all of them, and the evidence seems to me to be conclusive that such cases have occurred. The specimen which I show you seems to be a case in point. It consists of the uterus, tubes, ovaries and ligaments. The right ovary is the seat of a cyst, some three inches in diameter, which I believe to have its origin in a growing ovum. The cyst evidently springs directly from ovarian tissue, without such a pedicle as is usually seen in the case of small ovarian tumors. It is strictly a mucous cyst, there not being the slightest tendency to cystic degeneration in the remaining ovarian struma. The cyst walls are very thin and pliable, and are easily separated into two layers. The specimen, unfortunately, has no very decided history.



It was presented to me by Dr. Freeman, of Smethport, Pa., who gave it to me as a specimen of ovarian pregnancy. It was taken from the body of a married woman who died of obscure septic symptoms, the cause not being discoverable. At the autopsy this condition was found by Dr. Freeman. He states that when found the walls were perfectly transparent and that a foetus was easily visible through them. Unfortunately the specimen was frozen and then boiled for some time and later preserved in weak alcohol and water. When I obtained it the sac had not been opened. I opened it and was disappointed in not finding a foetus, but it contained a perfect placenta which was lightly attached to the sac wall. This placenta was a perfect concavo-convex lens in shape, and under the microscope shows enough to leave no doubt of its being placental tissue.

I feel sure that, although there is no foetus, this is a specimen of ovarian pregnancy. My reasons are, first, that I have the testimony of a most accomplished observer that he saw a foetus in it. Had this not been so, how would Dr. Freeman have thought of ovarian pregnancy? Would it not have been much more natural to take it for an ovarian cyst, a structure with which the doctor is quite familiar, he being an experienced ovariotomist?

Second. It contains a placenta, and I have no knowledge of placental tissue ever existing under any other circumstances than as the result of impregnation.

Third. The thinness of the sac walls and the entire absence of any other cysts in or around the ovary.

Fourth. From the nature of the pedicle which differs entirely from any small ovarian tumor I have ever seen. Such small tumors are quite common, occuring in the opposite ovary with large ovarian cysts.

Fifth. From the nature of the fluid which was contained in the sac resembling exactly ammotic fluid treated with alcohol. The absence of the foetus and cord may be accounted for by the treatment the specimen had received before it came into my hands, while the absence of sinuses over the placental site and the delicate attachments of the placenta may be explained by supposing that the death of the child occurred sometime before that of its mother. It has been suggested that this is a dermoid cyst, but to my mind there is not the slightest testimony in favor of this idea.

Dr. C. G. Stockton presented a specimen, handed him by Dr. Eugene Smith, of cancer of the liver and gall bladder. The disease was of the encephaloid tvpe, and appeared mostly on the inferior surface of the organ, involving the tissue around the portal fissure and, to a slight extent, the gall bladder. A large nodule was found on the superior surface at the extreme left and lower border of the right lobe.

Dr. Stockton stated that the woman from which the liver was removed appeared at his clinic where she was examined by a number of gentlemen. A well-defined tumor presented in the epigastric region, it transmitted the aortic pulsation, it was somewhat painful and sensitive, it seemed slightly movable but did not move with the diaphram in respiration, it was dull on percussion but all around it there was tympany save to the right, where, between the tumor (which was in the median line) and the free border of the ribs a dull tympanitic note was elicited. Nodules could be felt along the free border of the ribs.

The woman had been sick for some months, was emaciated and cachectic but was jaundiced only a short time before death. She ate very little and occasionally vomited food, gastric fluid and some mucous, but no blood. Hydrochloric acid was uniformly absent as shown by the phloroglucin-vanillin test. On inflating the stomach with air the tumor was brought to the surface and the tympany around it was increased. With the patient in the knee chest position the tumor dropped forward. Large enemata passed without obstruction to the cæcum. The patient referred all trouble to the growth in the median line above the umbilicus.

From these facts it was concluded that the tumor was a carcinoma; that the primary lesion was in the anterior wall of the stomach and that the liver was secondarily involved. He was not present at the autopsy but Dr. Smith informed him that the stomach seemed healthy and that, so far as was discovered, the disease was limited to the liver. How to account for some of the physical signs in view of the facts shown by post-mortem he did not know.

PROCEEDINGS OF THE ERIE COUNTY MEDICAL SOCIETY.

REPORTED BY WILLIAM H. THORNTON, M. D., SEC'Y.

The annual meeting of the society was held January 8, 1889, in the rooms of the Young Men's Christian Association. President J. D. Hill called the meeting to order at 10:30 A. M.

Upon a motion by Dr. T. M. Johnson the applicants for membership were duly elected. Vice President Banta was then called to the chair, and the president delivered the annual address to the society, the subject being "Forty Years in the Medical Profession." It was moved and carried that a vote of thanks be tendered to the president for his able and interesting address.

Dr. Dorland, chairman of the committee on the communication from the Georgia Medical Society, reported in favor of the following resolutions :

"Whereas a feeling of humanity suggests that all medical and surgical supplies,instruments and appliances, including those used in the diagnosis as well as treatment of disease, should be furnished to those needing them at the lowest possible price.

"Resolved, that the Medical Society of Erie County would urge upon Congress, that in the cause of humanity the import duty should be removed from all medicines, medical and surgical appliances, and from everything used in the treatment or diagnosis of disease.

"Resolved, that the corresponding secretary transmit a copy of the foregoing preamble and resolutions to the congressional committee on ways and means, and to our senators and representatives.

(Signed.) "E. T. DORLAND.
"JOHN CRONYN.
"ALVIN H. HUBBELL.
"Committee."

The report was adopted as presented.

Dr. J. B. Samo, librarian, presented his annual report as follows :

"The condition of the library is satisfactory in respect to the condition of the books. The additions during the past year have been 'The Annual of the Universal Medical Sciences,' in three volumes, and the publications of the Sydenham Society. Members desirous of drawing books can obtain them by notifying the librarian, 34 Tracy street. An appropriation for insurance, and also for subscription to the Sydenham Society is necessary to be made at this annual meeting.

"Respectfully submitted.

(Signed.) "J. B. SAMO,
Librarian."

On motion the report was accepted as submitted and the amounts asked for were ordered appropriated.

Dr. Crego read a memorial of the late Dr. F. R. Campbell, signed by Drs. F. S. Crego, B. P. Hoyer, and J. J. Walsh, committee, which was duly adopted.

Dr. E. Storck, chairman, said the Board of Censors had no written report to present. Since the last meeting the Board had had occasion to take action against one irregular practitioner who went under the name of a French professor, member of the Academy of Medicine in Paris. The Board gave him notice that, as he was not registered in the Erie County Clerk's Office, he was practicing in violation of the law, and that he would be prosecuted unless he desisted. He admitted that he had no diploma and never had studied medicine. He finally left the city, and was next heard of at Toronto, where he claimed to be a professor from the University of Buffalo. The Board of Censors is of the opinion that it should have the power to bring an action against irregular practitioners who, though they have a diploma, are not members of a county society. The Board calls attention to the fact that there are a number of students in the offices of members of of the society, who have not received a certificate from the Board of Censors, as prescribed by the by-laws. The Board does not intend to take any further steps in this direction ; only express regrets that the society does not comply with the by-laws in this very necessary matter. A motion was made and carried that the Board of Censors be authorized to take the necessary steps looking to making a test case against some of the illegal practitioners, at an expense not to exceed $150.

A committee consisting of Drs. Mann, Park, F. H. Potter, Stockton and Starr, was appointed to revise the fee bill of the society. A motion was entertained and carried that a committee of three be appointed to revise and publish a list of members of the society. This committee to include the secretary and treasurer as two of its members. The committee on nominations reported in favor of the following list of officers:

R. L. Banta, president; G. W. McPherson, vice president; Wm. H. Thornton, secretary; F. W. Abbott, treasurer; J. B. Samo, librarian; E. Storck, P. W. Van Peyma, Thomas Lothrop, H Lapp, H. R. Hoppins, Board of Censors; A. A. Hubbell, DeLancy Rochester, E. T. Dorland, Committee on Membership; R. Park, F. S. Crego, F. W. Bartlett, W. E. Pearsons, and E. H. Long, delegates to the State Medical Society.

The foregoing list of officers and committees was then elected.

Dr. Dorland presented in writing the following amendment to the by-laws, to be acted on at the next regular meeting: "Article VI., section 3. The secretary shall receive annually, at the expiration of his years' service, the sum of $100."

A vote of thanks was tendered to the retiring president and the other officers.

President Hill then introduced to the society President-elect Banta, who expressed to the members his thanks for the honor conferred in his election. Dr. Dorland introduced to the society Vice President-elect McPherson, who thanked the members for his election. The society then adjourned.

Translations.

THE ILLNESS OF EMPEROR FREDERICK III.

From Official Reports by Profs. Bardeleben, Von Bergmann, Dr. Bramann,
Profs. Gerhardt, Kussmaul, Drs. Landgraf, Moritz, Schmidt,
Profs. Schrœtter, Tobold and Waldeyer.

Especially Translated for "The Medical Press" from the "Deustche Med. Wochenschrift."

(CONTINUED FROM PAGE 49.)

After succeeding in this, he held the hook in one hand and pushed into the lumen of the trachea a slightly less curved canula, the identical one he had used at the first operation on the 9th of February. Immediately the Emperor breathed easily and freely, acknowledging it with a joyful and thankful shake of the hand. True, these manipulations caused some hemmorage, but only moderate. Also true that some of the blood and broken down tissue entered the trachea, as was shown by its continually extrusion out of the wound at each expiratory cough. It was soon coughed up, and with the reinduction of the canula the trickling of the blood ceased. One half hour later, when Wegner, Von Bergmann and Bramann took their leave, the sputum had reassumed its former brownish-red color. The entire proceedure of delitation and the introduction of the curved canula took but a few moments.

This proceedure has been represented far differently by Dr. Hovell and Mackenzie. The latter had only called Von Bergmann through courtesy and that Von Bergmann had insisted upon his introducing and that his assistant, not Von Bergmann, finally succeeded, etc. A few English papers, followed by the Berlin press, heaped an abundance of slander upon Von Bergmann in spite of the fact that, before his arrival the Emperor was suffocating, while shortly after his arrival he was breathing freely again.

It was manifest that the destruction of the cancerous growth in the larynx had of late not only made more rapid progress, but had also extended upon the skin about the canula. For on the evening of the 12th of April, as well as on the following night, Von Bergmann learned that for the past six days the Emperor had had fever.

According to the bedside notes regularly kept by Dr. Wegner, the fever existed since April 6th and had been steadily increasing. Because of the increase of the fever, the frequency of respiration and the failing of the royal patient, Prof. Senator was called in. On the same day Prof. Leyden was also asked to see him and did so on Tuesday.

Mackenzie thought that an inflammation of the connective tissue must have developed outside the trachea, perhaps in the mediastinum, since the forcible introduction of the canula on the 12th of April, that this was the cause of the fever. Prof. Von Bergmann, however, and showed how difficult it would be to diagnose small foci in the lung, but thought it very likely that they might exist, since for months past the cancer had been breaking down and the products had been finding their way into the bronchi. The bad odor of the breath, the increased frequency of respiration (44 per min.) and the singultus existing since Saturday, seemed to him to be due to putrid bronchitis. The increase of expectoration seemed to him to be due to spreading of the gangrenous ulceration of the tumor. Geheimrath Prof. Senator was of the same opinion. On Tuesday, April 17, the fever dropped and was soon followed by expectoration of larger quantities of pus. This circumstance possibly confirmed Mackenzie in his belief that a large peritracheal abscess existed, which opened into the trachea.

In the meantime there appeared in the "Kolnischen," the "National" and "Neue Preussische Zeitung," descriptions of the proceedings of the 12th of April, which accredited some of the Emperor's relief of dyspnœa to Prof. Von Bergmann. These provoked the explanations published by Mackenzie and Hovell, in the same papers, which were tinctured with animosity toward Von Bergmann. Many English papers reported the same proceedings of the 12th of April in the same aggressive way, and said that their information came from the English physicians of the Emperor (see Sunday *Times*, April 29th). When Von Bergmann was again called in on the 25th, after the temperature had fallen and the patients general condition was much better, he, considering Mackenzie's doings dishonest, sent him a letter, which was published later. In it he said that the newspaper explanations made it impossible for him to either speak or associate with him any further than was necessary for a consultation. He went still further and asked of Her Majesty, the Queen, that he be relieved of the necessity of consulting with Sir Morell Mackenzie. From the 30th of April Prof. Bardeleben took his place. Through the entire history of the sad illness of our patient and much-suffering Emperor Frederick, one detects the effort on the part of Sir Morell Mackenzie to attribute all natural, necessary and unavoidable progress of the disease toward the worse to some of his consulting colleagues. Gerhardt, he said, converted the original innocent inflammation into a more serious one by cauterizing it. In November and February it was desired that he be called with Schrœtter and instead of Kussmaul. It was said that that could not be done since he had been the cause of the bad turn of the disease. The bloody expectoration and the disturbance in the trachea were said to have been caused by Bramann's wrong incision, Schrader's clumsy change of the canula and Bergmann's choice of an improper canula. Finally, the latter was accused of having brought about the unfavorable change in the disease (which had existed since the 6th of April) by the forcible introduction of the canula on the 12th of April, thus causing the formation of a large fusiform abscess of the mediastinum. But the post mortem examination showed the mucus membrane on which the German canula rested smooth and without a trace of a scar or other irritation, and the connective tissue in this locality showed, as the operating pathologist had predicted, perperfectly normal conditions. The gangrenous condition of the carcinomatous infiltration extended only 2¼ cm. down the trachea. Every one of the canulæ, even the shortest, extended 4 or 5 cm. into the trachea. They all rested on healthy tissues and the tissues remained healthy. But from the time that Von Bergmann, on the 25th of March, found that the tumor had reached the canula, it was passed through and beyond the gangrenous portion until it reached the unaffected portion of the trachea.

The disease of His Majesty came to a standstill only for a short time. An evening rise of temperature was always present. It was a slow wasting hectic, and finally, when the pneumonia set in, the end came rapidly.

The last stages are described in the report of the Gehein Ober-Medizinalrath, Prof. Dr. Bardeleben. Before the post mortem examination, Sir Morell Mackenzie and T. Mark Hovell were ordered by His Majesty, Emperor Wilhelm II., to explain what they had considered the disease of the Emperor to be. The following are their answers:

Schloss Friedricheskron, 16 July, 1888.

According to my opinion, the disease which caused the Emperor's death was cancer. The process probably began in the deeper tissues and the cartilage of the larynx was very much involved from the beginning. A small growth which I discovered at the first examination of the deceased Emperor, I removed by several intra-laryngeal operations, and, although all the particles removed were submitted to the examination of Prof. Virchow, he was unable to prove the existence of cancer. However, the examination of expectoration, which Prof. Waldeyer made early in March, led him to believe that cancer formation existed at that time. Whether the disease was originally cancerous, or only took on a malignant character a few months later, is impossible to determine. The circumstance that perichondritis and caries of the cartilage played a very active and serious role in the development of the disease, undoubtedly contributed considerably to make it impossible to arrive at an early positive opinion on the nature of the disease. MORELL MACKENZIE.

June 16, 1888.

As far as my observations since last August allow me to form an opinion, it entirely agrees with that of Sir Morell Mackenzie.

T. MARK HOVELL.

Final reports of the post mortem examination and the microscopical examination of the body follow, and they are here given in full.

Physicians report, concerning the conditions found at the examination of the body of His Majesty, the deceased Emperor and King Frederick III.

Schloss, Friedricheskron, 16, July, 1888.

On the neck, closed by sutures, a linear wound 6½ cm. long, with somewhat dry edges, and on the right side of same a flat pale swelling 2 cm. long, 1.5 broad, and 0.5 thick is found. In the wound there lies a mass of cotton with bismuth, which removed leaves a cavity 5 cm. deep and nearly as long, and whose opening, after removing the sutures, gaps 2½ cm. The wound edges are quite hard, somewhat irregular, and tense. An incision is first carried along the middle of the sternum thence subcutaneously to the right and upward alongside the wound to the carotid where it had been injected. Section through the swelling mentioned above reveals a mass of quite tough tissue of a pale red color above and fading toward the deepest portions; on scraping the surfaces a white fluid exudes. It lies in the skin and partially in the deeper tissues, the muscles beneath it are, however, unaffected. Then a similar incision is carried to the left. Here also the muscles are normal excepting the upper portion where they are very tense. Immediately in front of the larynx there is a considerable swelling toward the left side, which shows a similar marrow-like infiltration.

On opening the thorax the first rib on the left side showed very marked ossification. The lungs pale-gray, entirely filling the pleural cavities and covering the heart. On the left side are seen several slight prominences under which are felt small nodular bodies covered with flabby layers of connective tissue; only in one place, near the anterior border, is seen a definitely bounded, lobular, polygonal figure with a pale, somewhat irregular surface. The left when raised, seems entirely free all round, contains air everywhere excepting the lowest margin immediately above the diaphragm. Very slight hypostatic congestion, the bronchi of the portion at the base containing no air, are dilated and are surrounded by hæmorrhagic areas. On section, a large number of foci are seen in the lobe, of which the most are surrounded by a hæmorrhagic area and of which the cut surfaces are grey, while in centre are found a larger number of smaller yellowish foci. In places they are as large as a pea with what seem purulent contents; others are not yet broken down. In the upper lobe are found similar pale foci in which are a great number of yellowish spots in groups. In the nodule on the anterior border, mentioned above, are found dilated bronchi plugged with a bad looking material, and surrounded by indurated tissue. The bronchi of the upper lobe are all found dilated and with thickened walls, the mucous membrane lies in longitudinal folds and covered with a bad looking granular material.

On the right side the conditions are much the same. The apex is free, while the posterior and lower portions show the same sprinkling with foci containing no air and the same conditions of bronchiectosis.

No accumulation of fluid in the pleural cavities. In removing the larynx the incision is carried beyond the œsophagus to the vertebræ. In the anterior mediastinum there is considerable adipose, the glands are slightly red, the rest unchanged.

The larynx and œsophagus are freed together and tied off. On the left side of the neck adjoining the jugular vein is found a gland of the size of a pigeon's egg, which on section shows a marrow-like interior with yellow spots.

Opening the œsophagus there is found, immediately behind the tracheal cartilages, a mass of superimposed layers of light-brown material; these removed, there is no sign of perforation. Epiglottis large, smooth, border normal.

The ligamenta-aryepiglottica, especially on the left side, are somewhat swollen, œdematous but without ulcerations.

The posterior space between the thyroid cartilages is quite deep, but contains no ulcerations. But at the base of the epiglottis, to the left, is a soft marrow-like node of the size of a cherry, beside a flat one and further outward several smaller nodules. Adjoining these is a ragged gangrenous area 9 cm. long, the lower border of which is formed by the trachea. From this place to the thyroid cartilages no cartilage is left, nor other tissues of the trachea. Of the thyroid cartilages only the upper and side portions with the horns are left.

The distance between the lower end of the tracheal wound and the lower end of the ulceration is 2¼ cm. This lower border is quite well defined, running transversely through the mucous membrane, and shows at its lower border small grey granulations, which would cover an area of about ½ cm. Then comes normal mucous membrane over the still normal tracheal rings. There are no nodules in the tissues about the portion of the trachea still existing, everything being normal.

This concluded the examination of the body and the latter was then carefully closed. The microscopic changes found were thus summarized by Professors Waldeyer and Virchow :

Cancerous destruction of the larynx with secondary infection of a large gland in the lower left portion of the neck and a cutaneous nodule to the left of the wound. Œsophagus not invaded. Gangrenous destruction of the upper portion of the trachea and surrounding parts. Numerous bronchiectases with putrid contents. In their neighborhood broncho-pneumonic abscess-forming gangrenous foci.

(Signed.) GRAF STOLLBERG-WERNIGERODE.
MORELL MACKENZIE.
T. MARK HOVELL.
J. WEGNER.
BARDELEBEN.
LEUTHOLD.
VON BERGMANN.
VIRCHOW.
WALDEYER.
BRAMANN.

Professors Virchow and Waldeyer's report on the microscopical examination of some of the specimens taken from the body of the deceased Emperor Frederick :

1. The larger one of the nodules found at the base of the epiglottis was covered with unchanged mucous membrane and cylindrical epithelium, in the tissue beneath these, however, alveolor arrangement with epidermal contents is found. The cells are large and well developed. Concentric arrangement of cell-masses was not observed.

2. The node found in the skin to the right of the wound is covered with markedly thinner but otherwise normal epidermis, the cancerous infiltrate has almost reached the surface. It was best developed in the deeper portions, here also numerous, very distinct "nests" with concentric arrangement of cells are found. Several normal constituents like sweat-glands are found in the cancerous masses.

3. The lymph gland from the left side of the neck is very decidedly changed. The normal structure is entirely lost and is replaced by a loose alveolar tissue whose spaces are crowded with epidermal cells having large neuclei.

4. The composition of the contents of the bronchi corresponds entirely with that of a nodule found in the expectoration and which was described by Prof. Virchow on the 19th of June of this year. Besides this there was found in several places a large accumulation of small glistening fat globules similar to those found in milk.

5. The foci in the lung showed dense masses of pus corpuscles, but no cancer cells. The natural alveolar structure was still visible.

(Signed.) RUDOLPH VIRCHOW.
WILHELM WALDEYER.

The brochure closes with these words of Von Bergmann : "Einer Epikrise bedarf es nicht." Most certainly not !

Book Reviews.

A CLINICAL ATLAS OF VENEREAL AND SKIN DISEASES; BY ROBERT W. TAYLOR, A. M., M. D. Part III., Venereal Diseases. Part IV., Diseases of the Skin. Philadelphia : Lea Bros. & Co., 1888.

ATLAS OF VENEREAL AND SKIN DISEASES; BY PRINCE A. MORROW, A. M., M. D. Fasciculi VII. and IX. New York : William Wood & Co., 1888. Buffalo : J. H. Matteson.

Part III. of Dr. Taylor's beautiful atlas begins with rupia and is devoted to the syphilides and the treatment of syphilis. It contains seven full sized plates with numerous figures which show the various characteristics of cutaneous syphilis in a thoroughly demonstrative way. Part IV., "Diseases of tne Skin," includes erythema, eczema, acne, psoriasis, favus. It comprises seventeen plates with numerous figures which certainly almost supply the presence of patients presenting the actual disease. We have called attention in a recent number to the conspicious beauties of Dr. Taylor's atlas and can only say here that the numbers as they appear show no falling off in beauty of illustration, accuracy of description or value.

The two fasciculi of Dr. Morrow's atlas are devoted, the seventh, to syphilis of the various surfaces of the body, the ninth, to erythema, urticaria, and eczema. Contrasting the two atlases we find the relative merits of each so great that comparisons would be invidious and useless. Plates can be no more like each other than cases can. Inasmuch as one never sees too many forms of diseases he cannot provide himself with too many of its pictoral representations. We do not regret the multiplicity of atlases but congratulate the student that so many opportunities for study of skin diseases are presented to him. Dr. Morrow is certainly carefully carrying out every promise made in his prospectus and is entitled to the gratitude, and his atlas to the patronage of every student of dermatology.

DISEASES OF THE KIDNEYS. By Prof. Dujardin-Beaumetz. Detroit, Geo. S. Davis, publisher. Physician's Leisure Library.

If Dujardin-Beaumetz ever wrote anything uninteresting it has escaped the notice of at least one eager reader. Those who peruse the pages of this work are likely to be moved to enthusiasm over its freshness, its originality and its arrangement. Little space is wasted in rehearsing old opinions that were better obsolete, but room is found for those facts which are established and numerous suggestions new and promising.

Every physician should read this book; and the chapters on Nephritis and Lithiasis should be read twice and thrice respectively. Dr. Hurd's translation is good as usual, but the few wood cuts are excellent examples of poor art.

HYSTERIA AND EPILEPSY. By J. Leonard Corning, M. D. Geo. S. Davis, publisher, Detroit.

This little volume constitutes another addition to the Physician's Leisure Library. Dr. Corning devotes about eighty pages to a description of hysteria, and treats the subject in an entertaining and intelligent manner. It is prolix, and yet, owing to the presentation of illustrative cases, a satisfactory account is given of the psychical, sensory, motor and vasomotor manifestations of the affection. About the same amount of space is taken for a description of epilepsy. To those who are satisfied with brevity at the expense of more or less important details, this contribution is commended.

The matter of therapeutics receives little attention.

BOOKS RECEIVED.

From Wm. Wood & Co., New York, through J. H. Matteson, Buffalo:
Lectures on Albuminuria: T. G. STEWART.

From D. Appleton & Co., New York, through Otto Ulbrich, Buffalo:
Displacements of the Uterus: B. S. SCHULTZE.

From Lea Bros. & Co., Philadelphia:
Diseases of the Nose and Throat: CARL SEILER.

From Geo. S. Davis, Detroit:
Bright's Disease: A. L. LOOMIS.

THE January number of the MEDICAL PRESS is both able and interesting. It contains original articles on the special treatment of diseases by Dr. Wheeler, Dr. Ely, and Dr. Park. The editorial is full of valuable suggestion to physicians, and the interchange of experience recorded can not fail to be of the utmost benefit. An interesting feature of the number is a letter from Dr. James Putnam, who, during a recent visit to Dr. Bernheim at Nancy, made some interesting studies of the hypnotic treatment so successfully employed by Bernheim. After witnessing numerous illustrations of the doctor's power over his patients, Dr. Putnam is still unconvinced of the virtues of hypnotism as a system of healing.—*Buffalo Courier.*

MESSRS. ELI LILLY & COMPANY, of Indianapolis, have issued a work entitled "Hand-Book of Pharmacy and Therapeutics." The aim, as stated in the introduction, is to furnish the busy practitioner a reliable means of ready reference, at once concise, systematic and authoritive, to which he may refer with confidence in case of doubt. Younger members of the profession and medical students will find this work full of suggestions. It will be sent free to any physician, druggist or medical student by addressing Eli Lilly & Co, Indianapolis, Ind., mentioning this journal.

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THE ETIOLOGY AND TREATMENT OF CERTAIN FRACTURES OF THE UPPER EXTREMITY.

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[An address delivered before the Central New York Medical Association, November 20, 1888.]

(CONTINUED FROM PAGE 70, FEBRUARY ISSUE.)

Fracture of the scapula is rare. I have never seen but two recent cases and in one, which was the first one observed, the injury was sustained a long time before the patient came to me. He was a passenger on a ship and was hurt on the voyage. On landing at New York he went to Dr. Carnochan, and the usual instrumental appliances were used. The other case was a man who was walking carelessly along the track and was struck by a locomotive. He was carried into the nearest house and suffered such intense pain that he could not bear to be moved. A young physician was called and he said to me afterwards: "I didn't know what to do so I put on your bandage." The effect was instant relief and the man got up and walked half a mile or more to his home. By this bandage the scapula is brought more nearly in apposition with the thorax and, by the tension of the muscles, is kept steady. Sometimes when a man has invented a thing he thinks it has more applications than it deserves, but usually it has more applications than he knows of. My friend, Dr. Slayton, has told me that the best way to dress the patient after the reduction of a dislocation of the shoulder was to use my bandage for fracture of the clavicle. Sometime ago I saw a case of dislocation backward on the dorsum of the scapula. It was reduced and went back, a case of consecutive luxation. It was reduced again and a pad was put in the axilla. It went out again. Then, as I recollect, Dr. Slayton put on my bandage and it remained in place.

Speaking of epiphyseal fractures at the upper end of the humerus, I have had to meet no little dispute and doubt. Sir Astley Cooper and other eminent surgeons, including Robert Smith, have thought it was exceedingly rare,but it is exceedingly often overlooked. The epiphyseal fracture at the superior end of the humerus is peculiar in presenting a right angle. When there is such a fracture of the humerus the muscles pull upwards and the result is to shorten the arm half an inch, and it will remain in that shape and will not yield to ordinary traction. Dr. Hamilton had a case where the patient was put under the influence of ether, and they constantly attempted reduction on two succeeding days. They stretched the muscles and thought the epiphyseal fracture was reduced; they let go and it went back. The remedy is to carry the arm up over the head. The reduction is analagous to a dislocation. The bones can be kept in place by various splints, but it is my custom to use Swinburne's extension splint, with a strip of adhesive plaster to hold it in position. Nature is kind to childhood. A boy twists himself into all sorts of misfortunes and nature twists him out. After a fracture of this sort which has not been properly treated because it was not understood, there is an apparent recovery, but later in life the patient will find himself unable to raise his arm above his head."

After my mind was clear on this subject I read a paper before the New York Academy of Medicine, and for the first time presented my views. After it was concluded there was to be an open discussion but nobody spoke. The president saw Dr. Buck, an eminent authority on fractures, sitting in front and asked him to speak. He said: "I have only to say that I know nothing about it. I never saw a case in my life." Dr. Little and Professor Post said the same thing. Dr. Hamilton spoke briefly but cited no cases. This was in New York City, and I read my paper Thursday. Before I left, the next Monday, I saw four cases. They had overlooked them. Dr. Little said; "I got my first case and tried the usual treatment raising the arm upward and outward. The arm was badly swollen, and ether was administered, and traction tried until the patient and the surgeon were exhausted. I said 'the arm should be carried upward and forward.' That was tried, and it succeeded, and my confreres gave me the credit of discovering the pathology and treatment of cases of this kind. I had a case of a young man or rather a lad of fifteen, whose shoulder had been fractured at the epiphysis. He had been appointed to the Naval Academy, and when he came to pass the medical examination, he could not put his hands together over his head. This would have caused his rejection but he was given a few weeks for treatment, and under this system he was cured.

In treating dislocation of the elbow the arm should be kept at right angles at first, and then the position should be changed to prevent anything like anchylosis. There was a case in Dansville, a place noted for malpractice suits, which attracted a great deal of attention from medical men. It was known as the Blake case, an ordinary case of dislocation of the elbow, and was reduced by Dr. Blake in the ordinary way. He was certain that the bones were in place because he heard them go in with a snap. You all know how easy reduction is at first, and no noubt Dr. Blake restored the parts to their proper place. He could not have failed. Then he thought that he could make his patient more comfortable by having her arm on a pillow, and he placed it at a right angle. It did not stay in that position, but slipped down to a compromise between a right angle and the straight position. Swelling came on and obscured the angles, and when this had subsided the doctor found a case of unreduced dislocation. A suit for damages was brought, and at the trial we all tried to find what the authorities had to say about it. We could not find a single word. Dr. Hamilton described a case of a boy in whom he was satisfied he had reduced a dislocation of the elbow-joint, but afterwards changed his mind. The boy was ungovernable, and as soon as the dislocation was reduced he refused to allow a splint to be applied and ran away with his hand in his pocket. The doctor could not get near him afterwards and the lad went about with his hand in his pocket until he was "cured." As the bone was out of place after apparent recovery Dr. Hamilton thought he had not restored it, but he had and it had been displaced afterwards because it was not kept in the proper position. The rule, "always place the arm at right angle," is laid down in the books and should be followed.

Colles' fracture is a subject to which I have paid great attention ; but I shall in the main content myself with quoting from papers of mine previously published, The solution of the peculiarity of deformity and the difficulty met with in many of these cases is found in the peculiar relation of the ulna to the carpal articulation of the radius, and in the luxation and ligamentous entanglement of the same.

"It will be remembered that the ulna does not articulate with the wrist-joint, but that its head, although covered with cartilage, and provided with a synovial membrane, and of course a complete joint surface, articulates with the triangular fibro-cartilage. The anatomists emphasize this arrangement so decidedly, that we are apt to forget the important fact of the articulation by the triangular fibro-cartilage by its distal surface with the wrist-joint. Thus the ulna has a mediate articulation with the wrist-joint, a fact of great practical significance. It will be remembered that the fascia of the fore-arm is very much strengthened at its lower end, and that the extensor muscles run in grooves constructed from it, and that its transverse fibres, under the name of the posterior annular ligament, runs across to the pisiform bone, some of them passing over the head of the ulna. The internal lateral ligament passes from the end and inner surface of the styloid process to the cuneiform bone. The triangular fibro-cartilage also subserves the purposes of a ligament, making an insertion in the pit at the base of the styloid process, but with a stronger attachment to the radius. The ulnar extensor runs in a sheath of the fascia, and as can be seen and felt upon the living arm, takes a course between the styloid process and head. But while it is really on the back of the fore-arm, it is so far upon its side that the tendon plays upon the side of the head and furnishes a lateral support. The tendon is just above the internal ligament."

The doctrine I have taught my classes for the last ten years may then be thus sufficiently stated. The fall comes upon the palm of the hand, and the radius which sustains the full force of the strain gives way at a point near the wrist. The line of fracture is usually an oblique one, starting from a point on the anterior aspect of the radius, near the articulation, and running backward and upward, making the posterior surface of the lower fragment longer than the anterior. It is seldom more than an inch from the joints, and seldom so far. But the line of fracture is very various, sometimes simple and nearly transverse, but often comminuted to the last degree. The luxation of the ulna exists in more than half of the cases. I now feel quite sure, though I cannot demonstrate it by dissection, that a proper observation of the relation of the head of the ulna to the carpus will made a just diagnosis of its luxation or non-luxation. The force of the fall may be just balanced by the strength of the radius, but in the nature of such accidents this would not often be the case. In most, there would be some force still to be borne. Upon what structure does this fall? The radius instantly, on fracture, ceases to afford resistance, the hand is carried still further back, and then comes the strain on the attachments at the end of the ulna. It will be remembered that the ulna does not articulate with the wrist, but there is a distinct synovial cavity between its head and the strong membrane called the triangular fibro-cartilage. The membrane takes an origin from the rim and side of the radius, and, covering the head of the ulna, is inserted in the pit at the root of the styloid process. As the hand, with its broken fragment of the radius, is forced backward, the strain is often sufficient to rupture the connection between the two bones or to break the ulna near the head. I have seen this double fracture twice only. The rupture takes place at the weakest point, which is its insertion in the pit at the root of the styloid process. But this is not the only resistance. The styloid is held to the carpus by the internal lateral ligament, which takes a very firm hold upon the end and radial surface of the styloid. This also gives way, and usually does so in a peculiar manner, viz.: By pulling off the surface of the bone, which proves to be weaker than the ligament. Thus the remaining styloid is brought to an edge like a gouge-chisel, and is shortened about one-half. When these resisting forces are disposed of, the end of the ulna, now laid bare, is pressed against the posterior annular ligament, and is apt to become engaged upon it either by a fold or, what is more likely, by splitting its fibres and hooking upon it. If very great violence has been used in the production of these lesions, the head of the ulna will be driven forward through the annular ligament and skin, thus producing a compound luxation.

"It is altogether probable that fracture of the radius may occur with which there is no complication of ulnar luxation. In these cases the restoration and retention would be easy.

"A good result with almost any treatment would also be probable. But a force competent to fracture the radius, if not expended, would generally be able to rupture the ligaments, in consequence of the immense leverage that the hand acquires with the head of the ulna resting mediately on the carpus. When the internal ligament and triangular fibro-cartilage yield, the annular ligament becomes slipped over the head and on the styloid hook. In order to determine the succession of movement in the ligament rupture, I subjected the arm of a cadaver to a force gradually applied, after having made a fracture of the radius just above the wrist-joint. This was effected by strapping the arm firmly down and attaching a lever to the hand, then bending the latter well back with a slow but irresistible force. The hand began at once to describe a circular sweep upward, backward, and toward the ulna; in short, such a movement as would necessarily occur with the short fragment held by the radio-ulnar ligament. The bulging of the ulna outward and downward preceded the rupture of the internal lateral ligament. But the fascia of the fore-arm lying on the ulnar head became stretched, and fibres of the annular ligament slipped over it. As the force was continued, a double snap, loud and sharp, was produced by the breaking of the internal lateral ligament and the triangular fibro-cartilage — apparently in the order stated. The end and internal surface of the styloid was broken off. The annular ligament at the same moment was caught on the styloid presenting precisely the appearance shown by the autopsy."

The mode of reduction is as follows:

The patient may be etherized or not. An assistant holding the fore-arm of the patient, the surgeon grasps his hand, the right with the right, and *vice versa*. With the other hand placed under the fore-arm above the fracture, he is enabled to bring the thumb over the back of the ulna, the fingers wrapping around the radius. Traction is first made by extension, then drawing the hand laterally to the radial side, then backward, next keeping it held backward, and while making extension, it is swung toward the ulna side, bending well laterally, when the extension of the hand is changed for flexion, thus describing nearly a semicircle in circumduction. The position of the hand grasping the fore-arm undergoes constant change, as it is the antagonist of the other hand in everything but the extension. As the backward position of the hand, when it is carried to the extreme ulnar side, is changed to flexion of the hand, the thumb of the surgeon rolls around the border of the ulna, and is below when the manœuvre is complete. The test of reduction is to be found by the presence of the head of the ulna on the radial side of the ulnar extensor.

The dressing which I have devised for these cases consists of a cylindrical compress about two inches long and half an inch thick — a small roller bandage, which is placed against the ulna, resting also on the radial border against the tendon of the flexor carpi ulnaris. A band of adhesive plaster of the same width is wrapped firmly around the wrist and over the compress, extending downward to the extreme point of the radius, thus grasping the bones neatly and firmly. The thickness of the compress raises the adhesive plaster so from far the anterior surface of the fore-arm that strangulation of the vessels does not take place. Moreover, the compress yields a little, and thus diminishes the pressure. A narrow sling passing under the compress, so as to bring the hand's weight to bear upon the ulna, completes the dressing. Indeed, even in the recumbent posture this should be done. With the weight of the hand thus carrying it to the ulnar side of the limb, the extensor tendons, placed upon the stretch by the drooping hand, retain the broken fragments with neatness on the back, while the adhesive strap, drawn with decided force, brings them together laterally. The method is essentially painless after reduction.

A short period of time for continuing the treatment, which has been adopted in the recent cases, has been justified by the results, and has been entered on for two reasons: Motion as early as possible after ligamentous repair is a cardinal principle in the treatment of luxation, and therefore desirable in these cases. Moreover, the fractured surfaces are broad and neatly opposed, and are in cancellated bone. These considerations induced the trial of fourteen days as the standard of time, which has been fully justified by the results.

"I SEE that bacteria have been discovered in Hudson River ice," observed Fangle.

"Ah!" replied his wife; "that will be another excuse for raising the price, I suppose."

DISCUSSION UPON CHRONIC ALCOHOLISM.

Held in the Buffalo Pathological Society, Jan. 18, 1889.

PATHOLOGY OF CHRONIC ALCOHOLISM, BY DE LANCY ROCHESTER, M. D.

There is no pathological leison peculiar to chronic alcoholism. The chronic congestions, fatty degenerations and sclerotic changes produced by chronic alcoholism differ in no respect from similar conditions produced by other causes. What is peculiar to chronic alcoholism is the series of changes produced in the different viscera by the habitual use of alcohol, and the train of symptoms to which these changes give rise.

It is my purpose to present to the society this evening, a few specimens of the more marked pathological changes produced by chronic alcoholism, prefaced by a few remarks on their probable pathogenesis. The first action of alcohol, which has been imbibed, is on the mucous membrane lining the gastro-intestinal tract, more particularly upon the pharynx and stomach, as, according to the experiments of Wood and others, most of the alcohol is absorbed in the stomach, little, if any reaching the intestine beyond. This action is at first stimulant, causing a hyperaemia of the mucons coat and increased action on the part of the secreting glands.

If, however, it is kept up by continued addition of the exciting cause, it changes its character, and instead of producing simply a slight hyperaemia causing an increase in the normal secretion of the digestive glands, it produces a permanent congestion resulting in chronic gastric catarrh — one of the earlier pathological changes in that train of metamorphoses which makes the body of a sufferer from chronic alcoholism a veritable pathological museum.

The deleterious action of alcohol in the economy is, in my opinion, largely due to the fact that it siezes upon the oxygen in the blood and so prevents the normal oxidation and consequent metamorphosis of the waste products, and causes the retention in the system of an excessive amount of deleterious matters which should be passed out by one or more of the various channels of excretion, the lungs, the kidneys, the bowels, and the skin, or else causes its excretion in a sub-oxidized form which irritates the organ excreting it. This last result of the general action of alcohol in the economy, and its local action upon the tissues with which it comes in contact are the principal casual factors in the pathological changes found in special organs.

It is to Virchow that we owe the knowledge that the pathological changes in an organ are due to changes in the separate cells composing that organ, brought about by the action of the deleterious agent.

Now, alcohol is absorbed as alcohol and circulates in the blood as such. Here it is in part decomposed, and from this medium it is in part excreted as alcohol.

In its passage through the economy it is necessarily carried with the blood to every organ and cell in the body and, although it is normally very rapidly excreted, if a fresh amount is constantly being supplied, the cells of all the organs are kept permanently in contact with a more or less concentrated alcohol.

What is the local action of alcohol upon organic tissue with which it comes in contact? It absorbs water, and so dries and hardens the tissue; it precipitates albumen from solution; it dissolves fat. The earlier pathological changes in alcoholism are those comprised under the head of congestion:—Congestion of the pharnyx, of the stomach, of the liver, of the brain, of the kidneys, of the spleen.

The local action of alcohol upon the pharnyx and stomach has already been referred to. The liver, being the organ through whcih all material absorbed in the portal system passes before it is distributed to the rest of the body, gets the full benefit of the whole amount of alcohol, and next to the stomach, is probably the first of the viscera to suffer. We must remember too, in this connection, that the liver contains one quarter of all the blood in the body and so gets a good soaking in the alcoholic fluid.

The other organs that are especially affected by the alcohol, are blood-vessels, heart, brain, kidneys and spleen. The reason that these organs are especially affected is that they all contain a large amount of blood, and so give opportunity for a large amount of alcohol to be present in them at one time.

In chronic inebriates who die suddenly while on a spree, or shortly afterwards, we generally find a very marked congestion of the kidneys and brain. In connection with these, in a large proportion of cases, we find a fatty liver and sometimes simple hypertrophy of the heart, sometimes arterio-sclerosis and valvular disease of heart with hypertrophy. But to return to the history of the series of pathological changes produced by the local action of alcohol. Next to the congestions we have the appearance known as 'cloudy swelling,' produced, in my opinion, by the precipitation of albumen in fine granular masses within the cell. These clouded cells next pass to a stage of fatty metamorphosis. If the individual still lives and continues in his intemperate mode of life, the fatty-degenerated cells are dissolved by the alcohol, the connective tissue is increased by fibrous deposit in and around the walls of the blood vessels, and drawing down upon the rapidly disappearing cells causes the contracted, sclerotic condition that marks the organs of an individual far advanced in alcoholism.

The effects of alcohol upon the circulatory system deserve special mention. In a large number of cases we find a simple hypertrophy of the heart, produced by the large amount of extra work thrown upon it in consequence of the great congestion of the kidneys. The endocardium and the intima of the blood-vessels, being constantly bathed with the alcoholic blood, we should expect to find further advanced in pathological changes than the other organs of the body; and, indeed, this is the case. Out of every 250 cases of chronic alcoholism observed by Formad, 50 cases showed that advanced state of sclerosis known as atheroma of the vessels and valvular heart disease. This condition of the vessels goes to further increase the hypertrophy of the heart and so to produce further changes in the brain, kidneys and other organs.

To sum up, the pathological changes brought about by chronic alcoholism are, in the order of their occurrence, congestion, cloudy swelling, fatty degeneration, sometimes calcareous degeneration. The organs most commonly affected are the stomach, the blood-vessels and heart, the liver, the brain, the kidneys and the spleen. Next to the blood-vessels and heart, the liver is the organ that is generally furthest advanced in these pathological changes, because it contains more blood than the other, and so is exposed to a greater amount of the deleterious agents. Few individuals live long enough for the sclerotic changes to take place.

Out of the 250 cases of Formad's mentioned above, 50 showed sclerosis of the blood-vessels; 6 sclerosis of the liver; 220 fatty degeneration of the liver; and 248 marked congestion of the kidneys.

It is the congestion of the kidneys and consequent cessation or diminution of urinary excretion that kills in the majority of cases of alcoholism.

I add a few notes from autopsies made by me last year in cases of sudden death in which there was a history of alcohol habit:

No. 8.—*Head.* Not examined.

Body. Well formed and well developed. Skull. Bloody froth in nostrils. "Allcock's Porous Plaster on chest." Abdominal cavity contains considerable serous fluid. Pericardium. Contains considerable fluid; marks of old pericarditis. Heart. Tremendously enlarged; marked calcarerous degeneration of aortic valve. *Abdomen. Spleen* very hard; congested. *Kidneys.* Both very hard; congested. *Liver.* Nutmeg; fatty. Stomach and intestines not examined.

I had intended to show the heart from this case, but it has been mislaid in the museum.

In explanation of the fact that the head, stomach and bowels were not examined in this case, and that the head was not examined in either of the other cases reported this evening, I would state that the post-mortem examiner is under the control of the coroner, and if, for political or other reasons, this functionary desires that the autopsy be incomplete, incomplete it remains. The head was not examined in any of these cases so as not to disfigure the corpse. The bowels were not opened in this case from a desire to prevent rapid decomposition as the body was to be shipped some distance.

No. 10.—Head. Not examined.

Body. Well formed, fairly nourished; slight rigor mortis present. Ecchymosis on ant. surface of both legs; scar on outside of left foot. Whole body much jaundiced. Abdomen filled with bile-stained fluid. Old peritoneal adhesion above liver. Arch of diaphragm on both sides opposite 5th intercostal space.

Chest. Pleurae, *left*, old adhesion over lower lobe of lung. *Right*, extensive old adhesion over whole surface of lung. *Lungs. Left*, slightly emphysematous, otherwise normal. *Right*, upper lobe normal; posterior lobe considerably congested.

Pericardium, normal, small subpericardial ecchymotic spots over ant. surface of left ventricle. *Heart*, size normal, possibly a little enlarged. Valves, mitral, a little thickened; tricuspid, normal; pulmonary, normal. Aortic holds water, but shows slight atheromatous dedeposit. Aortoic, slightly atheromatous.

Abdomen. Spleen, three times as large as normal, marks of localized inflammation of capsule. *Omentnm*, adherent in left ant. pelvis. *Kidneys.* both very large with adherent capsules; chronic intestitial nepnritis. *Liver*, very sclerotic. *Gall-bladder*, much distended with bile. Pelvic contents matted together in one mass of inflammatory products.

This case was not one simply of alcoholism. It was a harlot who had the reputation of being a very hard drinker. I do not doubt that alcoholism was a large factor in causing the pathological changes found, but it was well backed by intemperance in all things. I report this case to show the very advanced stage of sclerosis in which the liver is. (Liver exhibited.)

No. 14.—Head, not examined.

Body. Well formed, well nourished. Abdominal cavity contains slight amount of serous fluid. *Chest.* Pleurae, left, slight adhesion at apex. Right, adhesion over middle and lower lobes. *Pericardium*, marks of old pericarditis on visceral layer. *Heart*, hypertrophied and dilated; valves mitral, normal. Aortic, insufficient, with calcareous matter. Aorta. Marked atheromatous changes with calcareous deposits.

Lungs. Left, emphysema of upper lobe; engorgement of lower lobe.

Right, emphysema along borders of upper lobe; red hepatization of lower lobe. *Abdomen. Spleen*, bad sclerosis. *Kidneys.* Both very bad and engorged. *Liver.* Sclerotic. *Stomach.* Dilated. Chronic catarrh. Small intestines; engorged. Chronic catarrh. Color, normal. Bladder. Chronic catarrh; thickened walls.

I had intended to show the heart, liver, spleen and kidneys of this case, but on going to get them to-day I found them all in an advanced state of decomposition. The heart, however, still shows its size and the condition of its valves, and the aorta shows well its pathological conditions.

DE LANCEY ROCHESTER

THE DIAGNOSIS AND SYMPTOMS OF CHRONIC ALCOHOLISM, BY CHAS. G. STOCKTON, M. D.

Many and characteristic are the symptoms of this diseased condition, and yet, with few exceptions, they are but the expression of various morbid processes of which the continued use of alcohol is a more or less frequent causative factor. First, in the digestive apparatus, is to be found a stomatitis, usually catarrhal, with atrophy of the mucous membrane covering the tongue, which organ is red, dry, and heavily coated ; with its borders robbed of papillae, smooth, its centre having a pale, flaky coat, indented from the teeth and tremulous. There is excessive salivation or, exceptionally, the mouth is arid, and is fanned by a breath having a characteristic odor not suggestive of "Araby the blest."

Oesophagitis and gastritis, with their attending symptoms, attract attention. The deglutition of solid food is followed by vomiting. The latter symptom is conspicaous in chronic inebriates and is most commonly present on waking on the morning; the matter expelled being a tenacious mucous, often associated with blood. There are also pyrosis, flatulence and gastric distress, which symptoms are often aggravated by solid foods but relieved by the "morning nip."

These symptoms are accompanied by those of catarrh lower down; diarrhœa, interrupted by periods of constipation; the alvine discharges being slimy, sometimes clay colored, at other times deeply bile-stained. Bilious colic is not infrequent and biliousness is ever present with its attending train of evils.

Symptoms referable to the respiratory apparatus are cough, hoarseness and dyspnoea The shortness of breath is often dependant upon circulatory disturbance; for the over stimulated heart, the hypertrophied heart, with it frequent, full, soft pulse, is superceded by the enervated heart, the fatty heart—with failing circulation, pulmonary engorgements, fatty oxygenation and the usual physical signs.

The dilated capillaries and distended veins, the weak pulse—sometimes with difficulty felt through arteries deranged—lead gradually to those conditions of the integument which belong to all cases of chronic alcoholism. The red nose becoming livid, the sweating skin becoming dry and harsh, are exponents of the nutritive changes not only of the superficies but of more important structures further in. And the congested liver, a precursor of the cirrhosis that follows with ascites and visceral engorgement; the irritated kidneys, which leak albumen, are evidences that the nutritive disturbances within are directly related to the jaundiced and muddy skin, and the bleary, icteric eyes.

The symptoms of other degenerations are not wanting. Soft fat accumulates out of place—replaces the tissues of muscles to such extent that these parts are soft and their strength departed. Not rarely these will show degeneration re-actions on application of the electrical currents, the degeneration of muscle keeping company with changed nerve trunks, and together going to complete the picture of alcoholic paralysis. Thus we have the stumbling gait with dragging toes, extension being everywhere more faulty than flexion, ataxia, anaesthesiae and trembling.

While the paralysis is most pronounced in the lower extremities, the tremor is more apparent in the muscles of the face and hands. The old inebriate cannot fasten his coat, and while he generally succeeds in conveying the ardent fluid to his mouth, his shaking jaws rattle after the fashion of a castinet.

Other nervous symptoms—the enfeebled will and memory, the headache, the insomonia, the morbid fears and the delirium, the blunted special senses, and the depreciation of the moral nature, the convulsion and the coma, all make a portrait of chronic alcoholism easily enough recognized if not so easily described.

CHAS. G. STOCKTON.

ALCOHOLIC INSANITY. BY A. W. HURD, M. D.

The wide range of this evening's discussion leaves me opportunity to consider but a portion of the subject assigned me. First the term itself. If by alcoholic insanity is meant insanity caused by alcohol and is used as a convenient term to express causation, well and good; but if it is used to designate a particular and peculiar form of insanity not found under other causes, many alienists will demur; or, if going further, to the boundary approved only by a very few, the term is made synonymous with a spree or attack of delirium tremens the number who will object is overwhelming.

Let me state a generally accepted view: Alcoholic over-indulgence for a long period may cause either mania, melancholia, or dementia. It is not restricted to any one form. The same patient may be suicidal or homicical, or he may run the scale of varying mental states as in paresis. Or, he may have varying delusions either of grandeur or depression, being confined to no particular manifestation of pathognomonic symptoms. However, to consider the ground maintained by those who accept this name as a distinctive one we must admit that these patients *do* frequently have certain delusions, viz.: Delusions of persecution, of unfaithfulness on the part of wife or husband, and in general, delusions relating to the sexual organs, such as of malformation, atrophy, etc.

Indeed, one well-known writer (Spitzka) says on this point: "The combination of a delusion of mutilation of the sexual organs with the delusion that the patient's food is poisoned and that his wife is unfaithful to him, may be considered to as nearly demonstrate the existence of alcoholic insanity as any one group of symptoms in mental pathology can prove anything." However strong and well-put this may be, yet the fact that these so-called distinctive delusions may be, and often are held by patients other than those with alcoholic histories in itself disproves the right of this term to a separate place in the nosology of mental disease.

Delusions of a sexual character, of persecution, poisoning and infidelity are so frequently met with in these cases, however, that they should always be looked for when we are called to examine into the mental condition of one whose tremors, irritability, facial congestion and general physical deterioration proclaim the drunkard.

It must be borne in mind, however, that to be insane delusions they must be more or less permanent and exist apart and far from (in time) any effects of recent drinking.

It is probable that alcohol alone as the *cause* of mental disease has been given too prominent a place — too little consideration given to the accompaniments of alcoholism, viz.: starvation, cold, exposure.

The diseases which alcoholism induces appear much later in those well-to-do people who do not starve or expose themselves to the hardships met with by the gutter drunkard. The same holds true, to a certain extent, in mental diseases.

Time permits reference to two points only in this line: The close similarity between locomotor ataxia and the motor paresis of alcoholism either with or without accompanying dementia, is of great interest and is often difficult of differential diagnosis. The same may be said of general paralysis of the insane and this same dementia of alcoholic patients when associated with tremors and motor paresis. In both, time is an important element in differential diagnosis.

As regards alcohol as a cause of insanity let me quote statistics from a source possibly not at the command of every member of the society.

The United States Brewer's Association, prior to 1884, sent out letters of inquiry to 149 hospitals for the insane asking for their population and the number of patients whose insanity was credited to intemperance. Of the 149 addressed 54 were heard from, embracing the larger institutions. Many of the institutions not heard from were small ones and whose percentage, at any rate, would hardly be as near accuracy as bearing on this question as those of larger and more general hospitals.

In the 54 asylums there were 36,973 patients; of this number 2,334 men and 254 women, 2588 in all were assigned by the physicians as having alcoholism as the cause of their insanity. A percentage of 6.99, or in other words, less than seven in every 100 patients owe their insanity to alcohol. A suprisingly low percentage, suprising especially to those misguided minds who cannot regard an asylum as a hospital for nervous and mental disease and who think 99 per cent. of the cases are due to whiskey and masturbation.

A. W. HURD.

ALCOHOLIC INSANITY, BY H. R. HOPKINS, M. D.

In introducing the discussion of alcoholic insanity, your speaker is quite embarrased in making his selection of points to be left untouched. However the time at my disposal makes it imperative that I should offer for your consideration only a few brief thoughts upon a very limited portion of this most interesting and important subject.

In what sense, or with what meaning may we use the term "Alcoholic Insanity?" This is a subject upon which I have been obliged to read largely and to think continuously, and in what I am about to present to you as my mature conviction, you will find statements opposed to much that is written and spoken by eminent men—but sentiments supported by the utterances of a few practical men, who have spent much time in the study and treatment of mental disease, men who write but few books, and no long ones.

My proposition is that such a disease as alcoholic insanity, a disease having distinctive features, in causation, in pathology, in clinical history, or in termination, does not exist in experience, and can only exist as created by the disciples of Morel and Sekar in this attempt to construct the etiological classification of insanity.

The fatal fallacy of this system is shown by experience in the course of so-called various insanities—the manias, the hallucinations, the illusions, the delusions—the demented having the same characteristics quite regardless of the theory of causation and consequent classification.

I think the statement can properly be made that of the list of theoretical and ambitious systems of classification of insanity, none is more unpopular with practical alienists than the etiological, and that this system is the only warrant for the use of the term "alcoholic insanity."

This naturally brings me to what I want to present to you regarding the influence of the abuse of alcohol in the production of insanity; and I would again warn you that what I may have to offer upon this topic, is opposed to much that you can find in print upon the subject.

Medical opinion is not always above the influence of fashion, and of late the fashion has been to attribute to alchol the chief place in the production of disease in general, and mental disease in particular.

Had one the disposition, this society and this evening are not the place and time for the statement that the abuse of alcoholism has no pathogenetic power. The specimens we have had the pleasure of examining this evening bear ample testimony to the destructive power of the cup, but I would remind you of the wise and cautious manner in which Dr. Rochester announced to the society, that there is no specific lesion of alcohol found in any organ or tissue of the body, and that of the degenerations found to accompany its abuse, those of the brain are comparatively infrequent.

We must, therefore, recognize the existence of chronic alcoholism and remember that among its many tissue—degenerations must be numbered cerebral sclerosis.

The question as to the proportion of insanity caused by alcoholic intemperance is a mooted question. In the minds of many, most or a large percentage of all mental disease is caused by this view: That alcoholic intemperance, in common with every cause which can operate to depress human energy and to destroy man's health, may cause insanity. This must be admitted. That the potency of this factor in the production of mental disease is in many cases overestimated and overstated, is becoming year by year more apparent.

Slowly the truth is being recognized that the causation of disease is rarely single but often multiple, and the conviction prevails in many minds that drink, want, remorse, with heredity, cause many cases of insanity that a few years ago would have been charged to drink alone. In a rough and ready way it may be urged, that as drink caused the want, the exposure, the hardship, the remorse, it is in very fact the sole cause of the disease, and we may not blame the sociologist for this conclusion, but as pathologists such a method of reasoning can scarcely be permitted.

One thought in conclusion regarding the use of the word dipsomania. In the common aspect of the profession this term is frequently applied to hard drinkers where the habit is simply the exhibition of vicious propensity. In my judgement the word may only properly be applied to an insane person, in most cases the descendant of insane or neurotic ancestry, one in whom the drink habit is only a symptom of his disease and rarely the only sign of such disease. The drunkard may drink himself insane, the dipsomaniac drinks because he is insane.

H. R. HOPKINS.

TREATMENT OF CHRONIC ALCOHOLISM, BY J. H. PRYOR, M. D.

To discuss this portion of the subject in a general way it will be necessary to mention some of the prominent conditions with reference to therapeautic application. The essential thought of the whole matter lies in the fact that every manifestation of chronic alcoholism is due to insufficient or perverted nutrition. If this statement wins acceptance we must regard chronic alcoholism as a complex, ever-varying condition, not a distinct disease. If alcohol, like the typhoid germ, produced similar morbid changes whenever introduced into the economy, a line of treatment might be laid down in accordance with the law of the disease. But alcoholism rarely assumes the form of narcosis pure and simple, and its effects are traced everywhere. They may be slight or profound, dependant upon the amount for effects of the poison which exerts its toxic power in three ways. First, by altering function and causing prolonged narcosis. Second, by direct and constant action upon the cellular elements, which has been clearly described by Dr. Rochester; and thirdly, by disturbing assimilation and impairing nutritive changes. The first two may be called direct effects, the last indirect. Clinically the resultant manifestations are usually interblended. But the desire for careful treatment calls for discriminations. An attempt to differentiate between closely associated and independent conditions may be made by considering these factors of causation separately. Any substance taken in sufficient quantity to check or increase normal functions is a poison, and the so-called physiological effect of alcohol is simply evidence of its toxic influence. When deranged action is displayed as a symptom, however slight, a degree of narcosis is announced, and the continuous play of stimulation and sedation serve to portray a miniature clinical picture sometimes unrecognizable until deeper and irreparable changes have made the sad features distinct and unmistakable.

Opportunities to study the lesser phases of chronic alcoholism are so common that we are apt not to appreciate the true nature and meaning of the earlier aspects. Familiarity with a beverage and its temporary pleasures leads to the careless use of terms and questionable beliefs. Stimulation and intoxication are words not interchangeable and a deeper knowledge of the physiology of stimulation and sedation might prevent harm by restricting the scope of ill understood processes. Alcohol acts as a food and stimulant in certain diseased conditions by supplying a sustaining food or raising a depressed or lagging function to the standard of normal requirements. It may stimulate an aching nerve or failing heart, but that effect called overstimulation is simply the toxic effect, for the limit has been exceeded. To illustrate more clearly: The tired brain is stimulated and thought promoted. In health the power of reasoning thought is paralyized during the stimulating stage of intoxication. When alcohol is needed there is no recoil, when it is not needed repair must follow the damage to nutrition, which may be slight or unalterable. The earliest effects of chronic alcoholism are evinced by digestive or circulatory disturbance. The heart beats rapidly or slowly in accordance with the degree of narcosis. It is difficult to decide when stimulation ends or paralysis begins, nor can we say that stimulation must accelerate or sedation slow the circulation. The intricate and perplexing combination of nervous force which controls the vascular mechanism still eludes tangible definition, but we know that energy is multiple, diverse and marvellously balanced to perform a complex series of dynamic actions. The heart may be accelerated and the pulse increased in force by destroying the equillibrium of health either by inhibiting or paralyzing one system which checks, or stimulating another which hastens. At this time it seems unnecessary to refer to the theoies which are offered to explain the action of alcohol upon the circulation. Enough that an organ or nerve is overworked and its period of rest shortened or its activity lessened or, may be, stopped. The variation from a healthy standard becomes a stage of narcosis, and if the toxic effect be continued by accumulating doses the result is slow paralysis and disorganization. The peculiar form of pneumonia which is apt to accompany both acute and chronic alcoholism is evidence of this fact and shows the ultimate toxic paralysis of the sympathetic. I have incurred the risk of wearying you by dwelling upon well known facts, but they constitute an important part of the knowledge of the subject and should be recognized to render certain treatment successful. Ranging between the feeble complaint of the system, when a toxic agent is disposed of and tolerance seems to have been established, and the grave manifestations significant of destructive vital changes, are grouped the manifold features of an affection which shows only a repetition of disordered function caused by improper assimilation and impaired nutrition.

Alcohol may usurp the place of reconstructive foods and produce an indirect result in the way of starvation, or by robbing the tissue of oxygen, diminish metabolism and form suboxidised or was teproducts in the body which tend to toxaemia in its myriad aspects. The nerves which govern nutrition suffer paralysis, and digestion, absorbtion, reconstruction and elimination are interfered with by congestion and other vascular and nervous alterations. The primary toxic agent has indirectly given rise to associated and retroactive conditions, and other poisons develop to assist in destruction. Food supply is diminished and the prepared product vicious. The hungry cell is poisoned not nourished, and waste material collects with half-used elements because exertion is suppressed and chemical processes incomplete.

We may class these remote effects under the head of chronic alcoholism, or when distinctly marked, name them gout, lithiasis, gastric catarrh, etc., but the contributing influence must not be underestimated,

Organic lesions owe their origin and progress largely to this dual relation, and any attempt to furnish or replace degenerative loss must be based upon removal of the noxious material and improvement of assimilative functions. The fundamental points in treatment may be concisely stated in the following directions:

1. Remove the direct cause.
2. Control and remedy functional derangement.
3. Promote assimilation and elimination.
4. Supply proper food to nourish and repair.
5. Lessen dangers for organic lesions. Decrease misdirected effort. Encourage normal work and render it easy by encouraging co-operation and inter-dependant functions.

The necessity for discontinuing the use of alcohol in any form is imperative and the means to employ in accomplishing the purpose can only be discussed here from a medical standpoint. The habit should be checked before it is formed when diseased action is simple and apparently trivial. As a rule the task comes later and the difficulty often grows into a perplexing problem.

The chief point of practical interest seem to be grouped in these questions: Shall the drug be removed suddenly or gradually, and is the radical course ever fraught with danger? Shall a subsitute be offered? and what is the best article to employ? The first question cannot be answered by rule or hasty opinion. In the majority of cases undoubtedly the best plan is to cut off the supply at once, but I have seen a few instances where such a course would have imperiled life. The aged and feeble with a history of long addiction call for especial care. More than once I have watched complete withdrawal from a suffering patient who had passed beyond relief, and wondered if it were not prejudice and folly to increase distress.

There are many substitutes all of which are lauded by their friends. The idea seems to be to prevent craving. Some of the medicinal preparation quiet the harrowing system by supplying more alcohol, others impart a pungent burning sensation to the mouth or stomach and stimulate the blood supply; still more contain a bitter tonic which improves digestion, promotes appetite and causes desire for food. No ideal substitute can be offered unless it perpetuates what we wish to obviate, and the one which will encourage desire for proper food is the most valuable. I have found a combination of nux vomica and tr. cinchonæ co. the most effiacious. True these preparations contain alcohol but the amount is very small when the dose is considered. No drug has proved so beneficial in my hands as the tr. nucis vomicae for quieting gastric disturbance of an atonic character.

It should be continued only so long as its action is required and the appetite stimulated later by toothsome foods and hygienic measures. In controlling the functional derangements which result from continued use and are sometimes heightened by abstinence or acute exacerbations caution should be employed in the selection and use of drugs. We have only to remember that as a rule, the systems plead for rest and repair. These can only come from nutritious food conveyed to the tissues be it in the form of oxygen or its compounds. Proper help may be delayed by the injudicious use of sedatives to procure sleep or quiet perverted reflexes. The indications differ and no general rule can be offered other than this, that powerful agents such as chloral, morphia, hyoscyamus, etc., must be used guardedly, with special reference to the general condition and the functions of absorption and elimination. Cases of death are not uncommon where owing to the feeble and slow efforts at absorbtion and elimination consequent upon enervation accumulation of doses has failed to act for a time and then overwhelmed the weak powers of life. At times whiskey will succeed where chloral and morphine fail. Each case is a law unto itself and chronic alcoholism in any phase does not yield to stereotyped treatment. Most of the distress witnessed in any variety of alcoholism is due to checked elimination and inability to break up food products. The train of symptoms thus produced is endless. By giving attention to these we can do more for immediate relief than in any other way. This implies correction of digestive organs are excretions of excrementitious materials. The field is too large to touch even superficially and I shall leave it by merely referring to baths and especially the Turkish bath as an excellent adjunct to treatment in that direction.

The germ of the whole matter consists mostly in supply of reconstructive food, no matter whether the organic lesion be great or the nerve simply tired. That is the preventative and curative measure. I have long believed that the easiest way to stop drinking among the poorer classes is to give them a plentiful, well-cooked meal. In this way the desire or hankering for an artificial toxic substitute might be averted. This brings me to a division into classes always more or less distinct, where enviroment and social state modify the intristic pathology of such a disease as chronic alcoholism to a marked extent.

The rich, high-living, sedentary, chronic alcoholic offers a therapeutic problem very different from the poor, hard-working, ill-fed sufferer who frequents hospitals and dispensaries, One drinks a good beverage; the other usually a deleterious one. One injects a supply of food which his digestive organs cannot take care of, and in time he represents the effects of alcohol added to intestinal incompetence and triple lesion with some form of toxaemia. The other relies upon a poisonous material as a sustaining food with inadequate supply of nutritious and complete food. The economy is starved and his tissues having become accustomed to a fictitious and ephemeral stimulus call for more. The spur is applied again and again, but strength fails, tension loosens, and he fails to respond to the goad, for the faculties are perishing from hunger. Appetite is gone. Constipation is extreme. The secretions and excretions are locked up and the nerves which controlled them are partially paralyzed. Headache, indigestion, neuralgia and other symptoms or affections troop out to cry for food. These pictures are widely different, but all cases resemble one or the other more or less closely. The treatment is general, not special. It includes hygiene in every form. Easily digested food with a guarantee that the crude material becomes pabulum or reaches the cell in form for combination. Mixed in natural form or fermented as in "Koumys" it seems to be one of greatest utility. Its digestion can be assisted often by sodæ salicylas to prevent fermentation, or bismuth, or soda to neutralize acidity. Eggs provide the albuminoid constituent which seems to be very necessary. A copious supply of water is extremely beneficial in reducing congestion, increasing secretion and excretion; thus facilitating absorbtion and flushing out the eliminating organs to free the system from false products. Some of the meat extracts are well born when other foods are refused, and I have more than once coaxed the stomach to retain strong beef tea by giving it very hot with considerable capsicum. In regard to the organic lesions, such as cardiac, renal and hepatic complications, they are in a way an index to the tissue alterations elsewhere. The treatment must be largely hygiene and general in its nature. The central idea is repair, and the means of accomplishment have already been cursorily mentioned. When these have been complied with the subject becomes special and extends beyond the scope of this discussion, with which I have detained you too long. The endeavor has been to present a few salient points for consideration which are the outgrowth of experience.

ON THE INFLUENCE OF FLIES IN THE SPREAD OF EGYPTIAN OPHTHALMIA.

BY LUCIEN HOWE, M. D.
Prof. of Ophthalmology, Med. Dept., Univ. of Buffalo.

[Read before the Seventh International Ophthalmological Congress, in Heidelberg, August, 1888.]

As it was my good fortune to have some experience with Egyptian opthalmia while studying in that country the so-called "contagious diseases" of the eye, it occurred to me that a few observations concerning that affection might be worthy of record. At least, I hope they will tend to clear up the obscurity of a term long used loosely in ophthalmology, and besides, to point out a course which is of no small practical importance to the many sufferers there.

The term "Egyptian ophthalmia" it is well known came into use soon after the French occupation, and since then it has grown to have so indefinite a meaning that it will facilitate what I have to say later concerning the cause, if I first state the character of the disease, briefly describing its two leading peculiarities.

The inflammation of the conjunctiva peculiar to Egypt, is not, as ordinarily supposed, a conjunctivitis granulosa or trachomatosa. Such a condition does indeed exist in most cases, as a sequela—in a very obstinate, and frequently in a dangerous degree. Conjunctivæ presenting the typical picture of the granular form of inflammation are, therefore, extremely abundant there. But this condition does not invariably follow. Egyptian opthalmia is in reality a conjunctivitis purulenta acuta. Clinically it presents the picture of that disease as seen frequently elsewhere when it occurs in a severe form.

There are, however, two peculiarities about it, which may be considered as characteristic, and justify us in regarding the Egyptian ophthalmia as a special variety of the ordinary conjunctivitis purulenta acuta. These two distinguishing features are:

1. The fact that it recurs as a severe epidemic every year, and at the same time of the year—and

2. That it shows, among the Egyptians, a rather unusual tendency to result in corneal ulcerations.

First as to the epidemic character of the disease: During November, December and January cases do occur, but rarely. It is then only in the sporadic form as frequent as we find purulent conjunctivitis in other parts of the world, but not any more so. Even during the early part of February it is not common, and when three typical cases presented themselves there in the Government Hospital at the same time, Dr. Schiess-Bey, who is in charge, told me he considered me rather fortunate in the opportunity for observing them. From about that time, however, the cases began to multiply. By the end of March they are not uncommon, and in April or May material for study is abundant. I am told that the epidemic usually increases slowly but surely reaching its height about July or August, and then subsides with the approach of cool weather. Among the lower classes this is considered as one of the usual diseases of the summer, and by them is attributed to the dates, which ripen about that time, although there is really no more reason for blaming this fruit than any other. I must, therefore, consider this peculiarity so distinctive as alone to make this variety of conjunctivitis purulenta acuta differ from any we are accustomed to in northern climates.

A second characteristic is worthy of mention although not as distinctive as the first period: this is the tendency to corneal complications. There can be no question but that accompanying ulcerations and subsequent perforations occur more frequently than elsewhere; my attention was early directed to this point by the observations of Dr Lansing, of Cario, and subsequent experience caused me to concur most fully with him in spite of there being, as yet, no statistics to confirm the opinion. Not only is this shown by the results in cases under active treatment, and by the numerous anterior synechiæ presented at every clinic, but with all due allowance for the exceeding frequency of the disease it would be impossible otherwise to account for the large percentage of the blind.

The cause of this susceptibility of the cornea I have not been able to determine to my own satisfaction; there are, however, several facts which point to an answer to the question.

The lower classes of the Egyptians are notoriously dirty—and instead of washing the accreation off the lids when it accumulates there, as the result of such a process, it is simply allowed to remain, macerating the cornea. This is sometimes done in spite of the repeated injunctions of the oculist. Moreover the poor, as a rule, are ill-fed. Many never taste meat from one year's end to the other, and the supply of even vegetable food is not always sufficient, while malt liquors or other stimulants are seldom tolerated even for medicinal purposes on account of the religious belief.

Whatever may be the original starting point of this form of purulent conjunctivitis, I am inclined to the opinion that its epidemic character is due to the secretion being spread by the flies (Musca domesticæ). My reason for this are as follows:

1. The concurrence in time.

The disease is rare when the flies are scarce; it increases in frequency when they increase, and decreases when they decrease. There is unfortunately no question as to the rapid increase of flies during the season referred to, and almost in the same months as the conjunctivitis increases.

But this is not in any such ordinary quantity as the inhabitant of a northern climate would naturally suppose.

With the beginning of the first hot days the flies multiply with a rapidity which is simply enormous. They still remain one of the plagues of Egypt. In spite of the greatest care they abound, in the hot weather, even in the best arranged apartments and swarm near the kitchen and out-houses—but especially about the mud hovels of the poorer classes, being attracted there by the decomposing manure, unsavory dishes and general filthiness of the inhabitants.

2. The connection between the flies and Egyptian conjunctivitis is indicated by their identity of place. The epidemic occurs principally in the Delta, and near the rivers, especially in the towns where flies abound; it is rare among the Bedouins, and on the desert where

flies do not abound. This statement will be coroborrated, I think by any one who has had an opportunity for any observation in this respect; it is well recognized by the resident oculists with whom I have spoken.

Principally to satisfy myself as to this fact, I made two trips into the desert, extending over some twelve days. During most of that time I slept and ate with the Bedouins, associating constantly with them. My experience in Africa, as later in the Syrian Desert in the vicinity of Damascus, enables me to say without hesitation that cases of conjunctivitis in the active stage, as also its results, in the form of corneal cicatrices, are very much less frequent than in more habitable regions of the same latitude even when they are comparatively near. This point appears of special interest, when we remember in how many of the ordinary text-books we find so great stress laid upon heat, the influence of the sand or similar irritants as causes of conjunctivitis. To this I hope to refer more at length at another time.

3. The connection between the epidemic conjunctivitis and the flies is indicated by the negligence of the natives with regard to these insects. One who has not had ocular demonstration of this fact could hardly appreciate its full force. If a fly alights on the face or body of a European, his natural instinct is to brush it off. Not so with the Egyptian. Whether from early association or not, I do not know, but the fly walking over the skin of the latter seems to cause no irritation nor any annoyance—another fly may follow the first, or half a dozen, or fifty—and still the native sits quietly and apparently unconscious of their presence. With children this is particularly noticeable, their unwashed faces are favorite fields for flies that cluster in black patches about their eyes, noses, and mouths—and during the times when their cheeks are often smeared with the juice of the sugar cane, or of fruit equally as sweet and abundant. The negligence of the natives with reference to the flies is almost beyond credulity. I attempted to take some photographs illustrating this, but the aversion of all Musselmen to the making of a "likeness" rendered this difficult. An imperfect one taken with a detective camera, I succeeded, however, in obtaining and is here presented.

4. Experiment shows that the feet of flies are capable of carrying various forms of bacteria—and at least some of those found in the

conjunctival sac—in large quantities. If a fly walks across a gelatine plate and that be then placed in a suitable temperature for a day, every step taken can be distinctly traced by the growing cultures.

The facility with which the various forms are taken up and transferred from the conjunctiva is easily seen in a rough way, and one sufficiently exact for the present purpose—by fixing a fly to a pin and causing him to walk repeatedly across a prepared gelatine plate—the track, however, not crossing itself at any point. By so doing, nearly, if not all of the forms on the feet adhere to the gelatine and the feet are freed from them, as can be shown by subsequent incubation. If therefore, a fly, with his feet thus cleaned, is made to touch the conjunctiva and a second time, to walk over a gelatine or agar plate, the forms deposited by his feet will be found in some cases identical both morphologically and physiologically with those in the conjunctival sac. The details of these experiments made in the laboratory of the university in Cario, and in that of Prof. Pasteur, in Paris, will be given later. The fact is sufficient to establish the point to which I now refer, namely, the possibility of bacterial forms being transmitted by the feet of flies.

5. A conjunctivitis of the purulent type has been seen to follow the touch of a fly which before, had been on the other, similarly afflicted eyes. This was not an experimental inoculation, but due to the negligence of a patient under observation in Alexandria, on February 16th, of this year. As various sources of error may enter into the question of such inoculation, it cannot be considered as entirely conclusive, but the probabilities are strengthened by the fact that Dr. Tachow, of Alexandria, and others have told me they have also observed an Egyptian ophthalmia to follow the touch of a fly.

The conclusions from these observations are too evident to require elaboration.

As for the Egyptians, the necessity of cleanliness and of protecting the eyes from the flies, if necessary, by means of veils, all goes without saying, Even for more temperate climates, it is probable similar precautions would be advisable during the so-called hot season—when flies may be numerous, as they often are, in the dwellings of the poor in large cities. Under such circumstances, at least, when treating cases of purulent conjunctivitis, with other care and instructions to avoid the spread of contagion, we should not forget to warn the patient of the dangers which may arise even here from the ordinary house-fly.

PROF. LANG ON THE USE OF GRAY OIL IN THE THERAPY OF SYPHILLIS.

Translated for Med. Press from the Vienna Medizinische Presse, of May 1888, by W. A. Hoddick, M. D.

Metallic mercury in the form of Gray Ointment is universally acknowledged to have most potent curative properties. It occurred to the author some four years ago to use it in the form of subcutaneous injection. The preparation which Lang has employed during the past four years has the followimg formula:

Hydrargyni
Lanaolini, a a. 3.
Ol Olivae, 4.

This preparation contains 30 per cent. of mercury. In regard to the quantity of Gray Oil (as Lang calls his preparation) injected, experience shows that even small quantities have a decided influence upon syphilitic processes. Syphilis of moderate severity requires more than 0·3 cc. of the Gray Oil per week. After two or three weeks the greater part of the symptoms have lessened or entirely disappeared and then the quantity injected may be reduced.

Generally he injects every five to eight days in two places (nates or back) 0·1 to 0·15 cc. of the oil. After two or three weeks the symptoms have diminished and we may wait from ten to fifteen days before repeating the injection owing to the long continued action of the injected mercury. After this period has elapsed the injections are again continued in the same quantity but at longer intervals, or the interval between the injections may be the same, the quantity injected being reduced. This is continued until from 1½ to 2 cgm. have been introduced. Under all circumstances Lang warns us watch for buccal and other symptoms of acute hydrargyrum poisoning.

When one has become familiar with the technique, and has obtained a perfect preparation, paying strict attention to the rules of antisepsis, he will almost without exception have good results. The preparation is very well borne. During the four years in which Lang has used Gray Oil, he has had occasion to discontinue its use in only four or five cases. In these cases subcutaneous injections were either altogether intolerable, or there existed an idiosyncrasy against the use of mercurials.

The advantages of this method are as follows:

1. The mercury contained in Gray Oil is uniformally distributed, and the dose can be accurately measured.

2. The convenience of application.

3. Insignificant reaction. In many cases in which Lang has employed the method he has never had suppuration follow.

4. The real advantage of the method is that in Gray Oil mercury appears in the same form as it does in Gray Ointment.

The use of Gray Oil is indicated in all cases in which general treatment with mercury is required. There is no method which is more efficient, and in which the effect is so continuous. The best proof of the virtue of a preparation against syphilis is shown in the results obtained in lesions of the central nervous system. It is in just these doubtful cases of syphilis of the brain and spinal cord that Lang has abtained most satisfactory results.

Furthermore, of great importance is the fact that Gray Oil can be used where Gray Ointment or mercurial plasters would be unapplicable. Thus, E. G., one of Lang's cases, having a gummous excavation of the tibia, which opened exteriorily by a small sinus admitting but a probe, was caused by the injection of Gray Oil. Gray Oil is also applicable in the treatment of syphilitic processes in the larynx, nose, middle ear, or the eyes.

Dr. Maczek asked if the injection caused severe pain, and further, if Lang had observed how long it required for the oil to be absorbed, also, whether he had made clinical experiments to determine how long a period elapsed before the remedy was eliminated, as those preparations seemed most effective which were most slowly eliminated.

Dr. Eisenschutz asked if he had used Gray Oil in hereditary syphilis.

Dr. Teleky had used Gray Oil during the past two years upon the recommendation of Prof. Lang. At first he did not obtain very pleasant results, the reason for which, he was later convinced, lay in the fact that the preparation was not properly made. When the oil was prepared exactly according to Lang's directions, the results were better. The injection causes scarcely any pain. The resorption of the lumps, (injection) takes some time. Since the proper preparation of the oil suppuration has not occurred.

Prof. Lang in closing remarked that immediately after the injection the patient experienced no pain. On the following day a little infiltration is noticeable with some sensitiveness. This lasts from two to five days. After six or eight days the injected locality is scarcely to be discovered.

Parallel experiments made by Lang with calomel, show both subjectively and objectively that Gray Oil produces less reaction than calomel. He had made no experiments regarding the length of time the metal remained in the organism. It is not proved, that preparations which are rapidly eliminated are less efficient. He has not used Gray Oil in hereditary syphilis and would not recommend it in children because subcutaneous injection in general are badly tolerated by children, but in adults it would probably be effective.

THE THERAPEUTIC VALUE OF OXYGEN IN SCARLET FEVER.

BY D. ASTLEY GRESSWELL, M. D., OXON., M. R. C. S.

[From the Practitioner, Oct. and Nov. 1888.]

Dr. Gresswell has given to the scientific world a minute and carefully considered account of the natural history of an epidemic of scarlet fever, which occurred in London in the autumn and winter of '87-88. His article also describes the effect of oxygen in the numerous phases and complications of the disease. The patients upon whom these observations were made numbered 588 and were treated in Stockwell, a hospital of the Metropolitan Asylum's Board. During the year 1887 5,900 cases of scarlatina were treated in the board hospitals. Of these the greatest number 1272, were admitted in October, after this the disease commenced to wane and 761 cases were received in December. The average mortality during the year was 9·54 per cent., but among the cases treated in Stockwell the death rate was only 7·6 per cent.

Dr. Cresswell furnishes an interesting table showing among other things that the greatest number of cases, 205, were received at Stockwell in September, 1887, and the smallest number, 45, in January 1888. Sixty-four per cent. of all cases were under ten years of age, and among these children, 88·5 per cent. of all of the deaths occurred, showing the great tendency of young children to succumb to the disease. Less than 129 complained of sore throat and eight tenths of one per cent. suffered from renal convulsions; also, the characteristics of the epidemic during the various months of its prevalence were sharply defined. The disease reached its acme in October, and during the months of October, November and December, "facial dropsy of renal origin, inflammations of the middle ear, cervical abscesses, cervical adenitis, rashes other than the contagious and infectious, and marked slowing of the pulse" were relatively more general, while delirium and death were more common in November, although the treatment and hygienic conditions were the same in November and December. During the latter month the mortality diminished one half, showing a great change in the malignancy of the disease.

The author next analyses his cases in reference to the presence or absence of albumen in the urine. The agent used in testing was a solution of nitric acid, which when added to heated clear urine, gives an opalescense in the presence of albumen.

Every person admitted in October and November suffered from albuminuria, but a remarkable change in the type of the disease occurred in December and January, for 13 per cent of the December, and 26 per cent. of the January patients had no albuminuria at any stage of their illness. Dr. Gresswell adds to the value of his observations by separating the occurrence of albuminuria before and after getting up; for it is well known clinically that a patient with considerable renal mischief may have no albuminuria while lying in bed, whereas, after sitting up and walking about, large amounts of albumen may be detected in the urine. He says, "albuminuria before getting up was in fact a universal symptom in the October and November cases; on the other hand it was often absent from beginning to end in the December and January cases. Further, whereas 29 per cent. of the October and November patients examined had no albuminuria immediately before getting up. Only 12 per cent. remained free from albuminuria an hour or so after getting up, but, whereas, 66 per cent. of the December and January cases were free from albumen before getting up, not less than 48 per cent. remained free in this respect an hour or two after getting up." All the patients were clothed in flannels, the temperature of the wards was kept at 60° and every patient was confined in bed on a milk diet at least three weeks after admission.

The examination of the urine was evidently made with extraordinary care. Albumen from the genital tracts and urethra was excluded, and also epithelial and other detritus which occasionally gives a cloudiness to urine.

Many cases showed the curious phenomena of cyclial or punctual albuminuria, the albumen which appeared upon getting up disappearing when the patient was put to bed. This Gresswell ascribes in part to the increase in intra-renal pressure caused by standing erect, thus washing out any stagnating albuminous fluid from the glomeruli into the tubules and also to the more powerful arteries of the heart which would act upon the renal circulation increasing the amount of the glomerular transudation.

Most interesting is the account of the oxygen treatment. This was administered in two ways. First in the form of gas, 98 per cent. pure which was stored in metal cylinders and inhaled without further dilution, and also as oxygenated water charged under a pressure of 12 1-2 atmospheres in glass syphon bottles. This water was freely given, patients generally taking one quart a day, and judging by the avidity with which children and adults took it seems to have been a refreshing and palatable beverage.

Oxygen in hopeless cases seemed to ameloriate the dyspnoea and strengthen the pulse. A case is cited in which the patient laid eleven days with a scarcely perceptible pulse. With mild cases, in debilitated subjects, the oxygen apparently hastened convalescence, the patients gaining strength faster than in similar cases where the oxygen was not used. The effect of the oxygenated water was to relieve gastric irritability and to increase the amount of urine, thus flushing out the renal tubules. In cases where oxygen was used all other stimulants were not often indicated, no mean advantage in a disease often complicated by nephritis.

Dr. Gresswell next discusses the class of cases which although not severe in type are not necessarily fatal. A case of distinctly pyaemic type is described, with multiple abscesses, membraneous phatyngitis, rhinitis and albuminuria. No remedies except oxygen and astringents for diarrehea were administered and in spite of the long continued suppuration, delirium and weak heart, the patient made a complete recovery after an illness of 56 days.

In another case the oxygen had the effect of recovering the patients from severe syncopal attacks. A case of nephritis was complicated by uraemic coma with an excessively weak heart. The oxygen quickly restored the patient to consciousness. In this case the inhalations were frequently repeated, with the effect of diminishing the albuminuria and strengthening the heart.

Albuminuria and other effects of the oxygen treatment are next discussed. As we have seen albuminuria occurred in all of the October and November cases, while 21 of the 124 December and January cases remained permanently free from it. No oxygen was taken by these last patients. The tendency to albuminuria, therefore, diminished in December. With the October and November cases, even, when the amount of albumen was less than a shade while in bed, it enormously increased when the patient got up. Six only of the October patients remained permanently free after getting up, and all these had undergone the oxygen treatment. Although other patients had taken oxygen it had only been systematically given in these six cases. Of the November cases, which had no albuminuria after getting up, and were attacked previous to November 57th, at which date the liability to renal disease rapidly diminished. Of these eight, seven soon after had albuminuria; only one remained permanently free, and she was the only one to whom oxygen had been regularly given.

The reader must note the large number of cases, certainly 240, admitted previously to November 27th, and also the fact that all except seven had albuminuria, often functional, after getting up, and that these seven cases had been treated with oxygen and remained permanently free from renal trouble. It will further be observed that Dr. Gresswell has carefully followed the natural history of the epidemic of scarlet fever emphasizing the change in the disease in December and January, when albuminuria no longer complicated each case.

We must, therefore, agree with him that oxygen treatment was most beneficial, and regard his article as an important contribution to the already rich literature of scarlet fever.

Irving M. Snow.

A CASE OF PROBABLE SPINAL HÆMORRHAGE.

BY GEO. R. TROWBRIDGE, M. D., ILION, N. Y.

Jas. S———, an engineer, was admitted to the Rochester City Hospital on July 26th, 1887, at 2 o'clock in the morning, with the following history: While running his engine at a high rate of speed, he fancied he saw another locomotive a few hundred yards ahead of his own. He immediately applied the air-breaks and without looking sprang from the engine. When brought to the hospital the injured man was suffering from paralysis of both motion and sensation of the lower extremities and of the trunk as high as the nipples. The arms were not affected nor was there any cerebral complication. There were both retention of urine and constipation. Patient complained of no severe pains, but said his "neck felt stiff." Both ankles were badly sprained, but this was the only bruise or deformity. There was no evidence of fracture or dislocation of the vertebræ. At about 6 o'clock in the morning the patient's temperature was taken and proved to be 104°. A purgative was given and a short time after 10 grains of quinine. This had no effect as the following record of temperature will show. Internal medication was stopped and wet sheets applied to entire body.

July 26th: 9 A. M., 106; 12 M., 107 3-5; 2 P. M., 103 2-5; 4 P. M., 100; 5 P. M., 99 4-5; 6 P. M., 100 2-5; 7 P. M., 100 4-5; 8 P. M., 101 1-5; 10 P. M., 99 1-5.

July 27th: 2 A. M., 101 3-5; 4 A. M., 102 2-5; 6 A. M., 98 1-5; 8 A. M., 102; 10 A. M., 102; 12 M., 101 3-5; 2 P. M., 101; 4 P. M., 100; 6 P. M., 102; 7 P. M., 102 4-5.

The strange feature of the case was that the patient experienced no discomfort at the high temperature of 106 and 107 3-5°, and had it not been that the thermometer was used this extreme elevation would not have been noticed.

The man remained perfectly conscious until midnight of the 27th, then sank into a comatose condition. Death occurred at 2 A. M. July 28th.

The diagnosis made at the hospital was of concussion of the spinal cord; but it presents features too severe to be accounted for by any hpothesis save some gross lesion. Unfortunately no autopsy was permitted.

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URÆMIA AND ALKALOIDAL POISONING.

Uræmia willl ever be a subject of paramount interest to the profession, and any additions to our knowledge of its causes, its manifestations, or its treatment will be correspondingly valuable.

It is still believed by the majority of physicians that the group of symptoms known under the term *uræmia,* is caused by the retention of urea in the blood and tissues, notwithstanding observations made by many eminent experimenters showing that the feeding of urea to dogs produces little of harm or ill effects. By many it has also been shown that even the intravenous injection of urea produces very slight, if any, effect.

Frerichs evolved an ingenious theory, and supposed that the retained urea was decomposed into ammonium carbonate and that this new product produced the symptoms. Although this theory at one time had many advocates, yet to-day very few countenance it.

Flint says: "The *uræmic* symptoms are the result of the retention in the system of excrementitious materials. It is the entire mass of waste products and not any single element which is the source of trouble. The nature of these waste materials is unknown." A close search through the literature bearing on the subject shows how little is really known concerning the true cause of *uræmia*. With this fact in mind we are well ready to extend a hearty welcome to such a contribution as published lately by Thudicum (*Med. Press*, London, November 28th). Probably few workers of the present time have done so much towards solving this important problem as Thudicum, certainly none have done more.

While many early writers realized that urea is not the prime cause of *uræmia*, and though they hinted that the root of the evil was in excrementitious products, yet none did more than vaguely hint.

In all urine, normal and pathological, there exists nitrogenized bodies, *alkaloids*, other than urea and waters. Creatinine was the first one of this class of alkaloids isolated from the urine and definitely indentified.

Since 1879, Thudicum has isolated no less than six of these compounds, and determined three. He speaks of six, viz.: (1.(*Creatinine.* (2.) *Urochrome*, the yellow coloring matter of the urine. (3.) *Reducin*, an alkaloid distinguished by a *varium* compound, and some *remarkable reactions* of the reducing variety. (4.) *Urethrobromin*, a crystallized *isomer* of theobromin from cacao. (5.) *Alkaloid* giving an insoluable compound with zinc. (6.) *Alkaloid* containing an aromatic *neucleus* and giving a compound with platinic chloride.

In refreshing contrast to pre-existing uncertainty he says: *To my mind the alkaloids of the urine and their products of decomposition are the principal causes of the severe and not rarely fatal nervous symptoms characterizing uræmia.*"

Reducin, like some microorganisms, robs the tissues and blood of oxygen. Thudicum believes that this loss can even go on so extensively as to produce coma and convulsions. The peculiar hue and uriniferous odor so often marked in *uræmia* is due to the retention of urochrome, which alkaloid is also capable of producing convulsions. If ureia, when retained, works toxic effects it is only so after the quality becomes relatively large. This is so, perhaps, because of its extreme diffusibility distributing it so thoroughly among many excreting organs that its toxic qualities are not exhibited. To the deleterious effects of the retention of potash salts this writer gives very little credence, for the conclusions which caused other and earlier reporters to assign so much importance to the non-excretion of these salts were based upon experiments conducted with the lower animals and not from study of uræmic patients, and are to him not at all convincing.

Concerning the therapy of uræmic patients, we can see from the nature of *reducin* that giving pure oxygen meets a very plain indication.

In attempts to lessen the dropsy, so often incidental to Bright's disease, by diaphoresis we at the the same time reduce the accumulation of alkaloids and putting off the dangers of *uræmia.*

The tissues are frequently modified and injured to a surprising degree by the retention of urinary alkaloids in the economy, Which, perhaps, explains the tendency to phlegmonous inflammations that obtains in cases of Bright's disease, and the same may be said of the peculiar change which sometimes develops in the tendons, joints, and skin.

The writer in question relates a case of chronic uræmia in which phlegmonous inflammations occurred, where the cutaneous surface was much blistered, and where the blebs contained masses of urinary alkaloids. By this article alone, our attention is directed to substances which, it is shown, are competent when not excreted to give rise to symptoms similar to those of uræmia.

In other words, by it we exchange ideas that are empirical for those that are scientific. The subject is an exceedingly important and interesting one, and while it is to be regretted that our knowledge of the etiology of uræmia has advanced so slowly, yet it is pleasant to reflect that such observations as Thudicum's are being made, and at a not very distant day we may have a still better insight into its nature, and the indications for its complete control pointed out.

PROF. JOHN C. DALTON.

Dr. Dalton, late Professor of Physiology in the College of Physicians and Surgeons, died February 12th, at his New York home. He was and had long been a commanding figure in the American profession, and was known alike for his industry, ability and integrity. He was born in 1825, and graduated from the Harvard Medical School in 1847. He early devoted himself to the study of physiology, and four years after graduating won the prize offered by the American Medical Association, his subject being "The Corpus Luteum of Pregnancy." For some years he taught his favorite branch in the Medical Department of the University of Buffalo, and it was here in our home institution that he began to inculcate the lessons which he desired to imprint indellibly upon the minds of his auditors by experiments on living animals.

He was thus the first teacher in this country to resort to vivisection for class-room demonstration; a practice in which he has been ably followed by all his successors, Profs. Flint, Mason and Pohlman.

In 1855 Dr. Dalton accepted the metropolitan position which he filled so long and so ably, finally giving up active labor and assuming the presidency of the college. He was a busy worker, and his "Treatise on Physiology," which has passed through, seven editions attests the accuracy and value of his work. His "Atlas of the Topographical Anatomy of the Brain" is a monumental work than which nothing finer can be found. His loss will be sorely felt not only in local professional circles but by the entire profession, since there is, perhaps, no one to step into or fill the commanding position which he had carved out for himself.

* * *

Dr. W. E. Ford, of Utica, has been lately delivering a series of lectures upon "Medical Electricity" before the students of the medical department of the university. They have been copiously illustrated and have been made thoroughly practical, and have consequently been of inestimable value. The doctor has shown himself to be a teacher of such vigor and ability that not a few have expressed their wishes that he might be induced to take up his residence in Buffalo.

* * *

Dr. Z. H. Evans, of Bay City, Mich., an alumnus of the Buffalo school, class of 1872, has recently reported in the *N. Y. Med. Journal* an exceedingly interesting case of injury to the head involving the speech center of Broca, in which speech was restored some weeks later by elevating the bone that had been depressed. He argues from the peculiar features presented in his case that there are other centers for this function beside that comprised in the third left frontal convolution.

Within the past few weeks two notable discussions have been held in Buffalo societies, either of which would have done credit to the oldest society in the country. The first, on "Chronic Alcoholism," took place in the Pathological Society, and will be found in full in our pages. The papers will amply repay careful perusal. The second was on the subject of "Late Syphilis," and was held at the last meeting of the city association. It called out an unusually large attendance and excited very general interest.

The expedient having proved so successful, should be repeated at proper intervals, and with the right men leading, and a happily selected topic, will always draw a good audience.

* * *

Dr. J. P. Cochran, of Oroomiah, Persia, has been making an extended visit to this country after an absence of many years. He will be most pleasantly remembered by those who have read his contributions to The Medical Press in previous volumes. He is in charge of a large Mission Hospital whose sphere of Christianizing and humantarian influence extends over a large area of Persian territory, and which is located among a people where the vicissitudes of practice are widely different from those met with in this country.

Upon his return, which will soon occur, we hope to lay before our readers more of his interesting reminiscences of a physician's life in the far East.

* * *

The many friends of Dr. F. S. Peterson will be glad to learn that he has recently been appointed chief of clinic in the Nervous Department in the Vanderbilt Clinic, at the College of Physicians and Surgeons, and that he has also been made attending physician to the New York City Hospital for Nervous Diseases, on Blackwell's Island. Since the doctor's removal to New York he has been located at 34 East 21st St., where he has now fully established himself as a specialist in nervous diseases.

* * *

Any student or physician wishing to study German or French, or to practice conversational exercises in either of these languages, can find an excellent opportunity by addressing Prof. Henry Frank, 508 Pearl St.

Dr. John Parmenter and Dr. J. W. Putnam have returned from their protracted European trip to resume practice in the particular fields to which they have been devoting eager and special attention. Dr. Putnam will hereafter give his time mainly to nervous diseases, and Dr. Parmenter, whose last London letter arrived too late for our February issue and consequently appears in this, intends to devote himself to general and special surgery.

* * *

The Annual Commencement of the University of Buffalo, Medical and Pharmacentical Departments, will occur Tuesday, March 26th. The ovation to the graduating class will be delivered by Prof. Ansley Wilcox, and that to the Alumni by ———.

The programme for the Alumni meeting is scarcely complete enough to permit its publication so early, but a number of very interesting features will soon be announced.

It is hoped that the association will this year be joined by many of the Alumni who have as yet failed to perfect their membership.

Society Proceedings.

BUFFALO PATHOLOGICAL SOCIETY.

Regular meeting January 18, 1889. The president, Dr. Park, in the chair.

The principal part of the evening was devoted to a symposium on the subject of "Chronic Alcoholism," the papers which were read being published in another part of the present issue.

In the general discussion which followed, Dr. Fredericks devoted a little time to the question of total withdrawal of the drug, and the dangers of this practice in certain cases.

Dr. B. G. Long spoke of the difficulty of treating such cases at their homes and the great advantage of having them in public institutions. Also of the necessity for legislation that would permit placing chronic inebriates in asylums or retreats.

Dr. Eli Long spoke in defense of the view that alcohol is food. Dr. Wall called attention to the many appropriate uses of alcohol in some form as contrasted with its abuses, which latter he thought had been unduly emphasized.

Various members gave their views as to the best drugs for palliation of the most prominent evils attending inebriety; of these remedies tincture of valerian in half ounce doses frequently repeated, solid extract of nux vomica in large doses, and nitrate of strychnia seemed to stand in most favor.

Dr. Mann presented, for a candidate, a malformed fœtus. The mother was a primipara of 35 years, and herself showed abnormalities of development, having congenitally small ears with impairment of hearing, and a misshapen pelvis. The presentation was by the breach; forceps were applied, a leg reached, and the child's body delivered as far as the head which on account of its size, could not pass. Delivery with the blunt hook in the mouth not succeeding, craniotomy was performed. The fœtus presented talipes varrus of both feet and a spina bifida; also a very large hydro-cephalic head measuring 48 cm. (19in.) at the level of the occiput and 51 cm. around the chin and forehead.

Dr. Eli Long presented the specimen from a case of placenta prævia, with overlapping into the os and marginal implantation of the cord. Mother and child both were saved. Also a typical case of miliary tuberculosis of exceedingly rapid progress, the patient having worked till three weeks before his death. Only one hæmorrhage had occurred; prior to this there had been but few physical signs of trouble.

Dr. Hinkel presented three specimens. The first a black crust from the trachea of a patient who had been under treatment for atrophic rhinitis, who developed cough, sweating and severe dyspnœa. Examination revealed a trachea dotted with and obstructed by numerous scabs or crusts. Relief was given by moist inhalations.

He also presented further the malleus removed from the left ear of one patient and another removed from the right ear of a second. The bones were removed according to Sexton's plan and views for the relief of intractable middle-ear discharge, and with marked relief. Time had hardly elapsed in which to claim a cure. Both bones were necrotic and had acted as foreign bodies.

Dr. Frederick related the case of a child with abscess in front of, and below the right ear, rupturing after three weeks into the external auditory meatus, and thus discharging for two months. The post-auricular glands had enlarged and facial paralysis on that side had occurred. Whether the paralysis was due to a neuritis or to pressure from the enlarged glands was the question upon which he desired help.

Dr. Park related briefly the main features of a case of abscess of the lung, discharging through the thoracic wall in the neighborhood of the nipple, after opening a subcutaneous collection of pus. It had previously discharged by the bronchi and mouth. The pus was extremely fœtid and must have arisen from a gangrenous condition.

He also exhibited preparations from two specimens. The first, a section of a tumor of the breast which, clinically, presented every feature of benignancy, yet showed, under the lens, distinct evidences of scirrhus structure. The second was a slide from a tumor, the size of a fist, which had been found by the cook in the belly of a fowl that was being prepared for the table. He could not learn its exact site in the abdomen. Microscopical examination revealed a typical picture of adenomatous structure.

The former secretary, Dr. Matzinger, having resigned; Dr. E. A. Smith was elected to fill that position.

Correspondence.

LONDON LETTER.

LONDON, February 1st, 1889.

Dear Doctor:—For any one wishing to study the various forms of malignant disease, the famous Brompton Cancer Hospital affords great opportunities. This institution, founded by Dr. William Marsden in 1851, has over one hundred beds, and they are always filled. In addition there is the out-patient department upon which about fifty patients are in daily attendance. All kinds of cancer and allied diseases come under consideration, and recieve treatment at the hands of men who have given this branch of surgery long and thorough study. I have been for some time past under Mr. Jesset's teaching, and can speak only in enthusiastic terms of him as a diagnostician and operator. Tuesday and Saturday are operation days, when eight to ten operations, on the average, are made. All the surgeons here believe in extirpation as early as possible, and also that, when this is done, life is considerably prolonged. Antiseptics are very rigidly insisted upon, and their results are in every way good.

Another of the excellent special hospitals in London is St. Mark's for Fistula and Diseases of the Rectum, where I have been in constant attendance. The names of Allingham, Hill, Cooper and Edwards show the surgical talent which holds sway there, and, indeed, one can see most thorough and satisfactory work in this important class of diseases. Mr. Edwards' out-patients number about sixty daily, and of course, present all phases of rectal maladies. Hemhorrhoids predominate here as elsewhere, and are almost exclusively treated by him with injections of carbolic acid, 10 to 20 per cent. being the most usual strength employed. Fistula in ano is tubercular in origin in about 10 to 15 per cent. of all the cases, and all are incised, except those occurring in advanced phthisis. The results seem to fully justify the treatment.

Mr. Edwards is also surgeon to St. Peter's Hospital for stone and genito-urinary diseases, at which institution the clinic is likewise very large. Upon its surgical staff are also Coulson and Fenwick, and the treatment is of an advanced scientific kind.

The Soho Square Hospital for diseases of women is another place well worth a few weeks attendance under Dr. Holland, whose clinic I have been following. One sees about one hundred and fifty patients on each of his attending days. This includes about twenty new cases and scarcely any disease fails to come repeatedly under observation. Dr. Holland is a good operator and makes many abdominal sections with good success. He rarely uses the speculum or sound, his fingers conveying to him all the knowledge he requires for diagnostic purposes.

The Samaritan Hospital for Women is more famous than the one first mentioned, and should be seen, for here abdominal surgery is better studied than anywhere else in London. The clinic is enormous, and under the direction of Bantock and Thornton, is used to the best advantage. Their splendid success attests their ability. The results of each seem about the same, notwithstanding the fact that they differ widely upon their views on antiseptics. One sees repeatedly the most bold laparotomies, no case seeming too desperate for operation.

I have purposely avoided mention of any of the famous medical schools which are too well known to require it. The practitioner coming to London will find the smaller hospitals which are unconnected with any teaching bodies by far the better places in which to study. In these one avoids the crowding of students and the elementary teaching which they naturally require, and, furthermore, the cases can be examined personally. In some out-patient departments, if one manifests sufficient ability, he can direct the treatment, under certain restrictions of course. For these reasons they are to be preferred, and the mention of some of them may be of use to any readers of the PRESS contemplating study in London.

To speak of the noted surgeons connected with universities here, with whose work I am familiar, would take too much space, and I shall content myself with merely mentioning them. They are Lister of King's College, Heath and Horsley of University College, Treves of the London and Morris of the Middlesex hospitals. Mr. Horsley, whom many Buffalonians had the pleasure of meeting last autumn, is making famous strides in brain and spinal-cord surgery. In the last few days, I have seen him make four major operations, two of them for brain tumor, one for the removal of the 7th, 8th and 9th dorsal laminae in a case of parapligea, and one of attempted section of the fifth nerve behind the Gasserian ganglion. I say attempted, because the operation could not be completed on account of hemorrhage, and the nerve was divided in the spheno-maxiliary fissure. All the patients have recovered from the operations and it is expected will be much improved by the same.

Lister, Heath and Treves are all excellent surgeons and teachers, and in the course of their remarks upon cases, are constantly giving out sound principles and good practical points in treatment.

I can not close this letter without a few words about Mr. Henry Morris of the Middlesex Hospital. To my mind he combines many of the qualities of the ideal surgeon. As a teacher he is clear and painstaking, giving his opinions in a concise and impressive way, and as an operator he is not surpassed by any one I have ever seen in London. His wonderful success in kidney surgery has given him an international reputation and put him in the first rank of surgeons. It has been my good fortune to see much of his work and to be an eye-witness of his remarkable power in interpreting symptoms in cases of renal calculi when the data have been scant and obscure. His collection of calculi, fifteen in number, represent an unbroken series of recoveries and speaks for itself. His work on Diseases of the Kidneys is doubtless well known to your readers and is one enjoying a high reputation among English surgeons. Mr. Morris is very affable and takes much pains in showing his cases to visitors at his clinics.

Very sincerely,

JOHN PARMENTER.

Book Reviews.

THE YEAR-BOOK OF TREATMENT, for 1889. Philadelphia: Lea Bros. & Co.

This little book contains a "critical review of the practice of medicine and surgery during 1888." The contributors are English writers of acknowledged ability in fields of special work, and they have presented in concise form the more important additions to medical literature during the past year. Publications in many languages have been searched and wise discrimination employed in selection that the busy physician may glean with little labor the results of much thought and active investigation in many lands.

The increasing number of complications of this nature should cause congratulation. Interchange of knowledge is stimulated and the mass of the profession is afforded an opportunity to extend the range of reading beyond the limits of one language or the pages of a few journals.

HAND-BOOK OF MATERIA MEDICA, PHARMACY AND THERAPEUTICS. Compiled for the use of students preparing for examination. By Cuthbert Bowen, M. D., B. A., editor of "Notes on Practice." Philadelphia and London: F. A. Davis, 1888.

The design of the author is definitely announced, and the contents of the book show it to be an exhaustive quiz-compend intended to teach tersely by direct question and answer.

Any aid in the form of a hand-book kindly bestowed upon the suffering student is apt to stir two opposing currents of opinion. The professor often condemns and indulges in trite criticism because information is condensed to a dangerous degree of superficiality. On the other hand, the student desires a ready method of obtaining essential facts to obviate prolonged study when time is limited and accumulating work grows ponderous. This demand is supplied in an unusually competent manner by Bowen's Hand-Book.

The arrangement and text of the questions and answers are admirable, and the only objectionable feature of collected formulæ will do trifling harm to the properly instructed. Evidence of experience in the quiz-room is manifest and the author's familiarity with requirements for examination has served to produce a safe companion and guide in a large and difficult field of study. Considered in relation to its purpose, we know of no book more thorough and praiseworthy, and believe that it will gain especial favor where educational systems are so imperfect as to render additional help necessary. J. H. P.

HAND-BOOK OF THE DIAGNOSIS AND TREATMENT OF THE THROAT, NOSE AND NASO-PHARYNX. By Carl Seiler, M. D. Third Edition, thoroughly revised and greatly enlarged; with two lithographic plates, and 101 wood engravings. Philadelphia: Lea Brothers & Co., 1889.

The enormous increase of medical literature, in monographs, and volumes more or less exhaustive, upon every phase and subdivision of medical science and art during the past decade, compels us in self-defense to question closely each new contribution as to what, that is original or serviceable, it has to add to our store. If it fails to meet this test, the conscientious reviewer is bound to warn his readers against the waste of time involved in its perusal. Only thus can we stay the deluge that threatens us from immature ambition and eager publishers. The third edition of this work presents nothing not already familiar to students of the upper passages, and but little not already presented in equally concise and complete manuals. However, this edition has several points of excellence over the previous editions and offers a short, and on some points, excellent resume of laryngology and rhinology for the general practitioner; though in some descriptions of pathology and therapeutic procedure it is too inexplicit for the beginner and not profound enough for the advanced student. The account in the first chapter of the present application of electric lighting for investigating the upper passages is excellent, as would be expected from so skilled an electrical amateur as Dr. Seiler.

The cuts illustrating correct and faulty laryngoscopy are instructive, as is the ingenious diagram of a model for illustrating the intricate effects of intra-laryngeal muscular action. In the chapter on physiology the description of the mechanism of the "registers" and of their limitations, is perhaps more exact than our present knowledge warrants; but the physiology of articulate speech is described with cleanness, excellence and novelty—indeed, it is the most satisfactory part of the book. The varieties of "nasal catarrh" are well described, and their treatment—especially the treatment of hypertrophic catarrh—is given with detail and completeness. One notices, however, too many cuts of instruments described as the author's that are but slight modifications of instruments that are in the hands of every rhinologist. Nasal polypus receives too slight consideration for so frequent and important a disease. A few chapters on hay fever give a resume of that subject. The causative scope of "pollen" is unduly belittled in view of the evidence, and there is too positive an attitude as to results of local treatment in this affection. This is a fault shown by most writers on this topic. In fairness it should be admitted that failures to "cure" are not infrequent. The results of treatment in any nervous affection must be studied and compared with care not to be misled between *post hoc* and *propter hoc*. The table of symptoms of diseases of the larynx and naso-pharynx, given at the end of the volume, seems superfluous. The symptomatology of diseased conditions of the upper air tract is so vague and so inferior to inspection for the purpose of differential diagnosis, that its consideration in this form does not appear to be of much moment. The typography of the book is excellent, and it is freely and well illustrated. The beautiful lithographs of the appearance of the larynx in various diseased states are particularly noteworthy. H.

BOOKS RECEIVED.

From Lea Bros. & Co., Philadelphia:
  Year-Book of Treatment for 1889.

From D. Appleton & Co., New York, through Otto Ulbrich, Buffalo:
  Exploration of the Chest: S. S. BURT.

From F. A. Davis, Philadelphia:
  International Pocket Medical Formulary: C. S. WITHERSTINE.
  Electricity in Diseases of Women: G. B. MASSEY.

From W. B. Saunders, Philadelphia:
  Questions and answers on the Essentials of surgery: EDWARD MARTIN.

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PARANOIA.

BY A. W. HURD, M. D.

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[Read before the Buffalo Medical Club.]

In presenting this paper to the members of the club this evening it is my aim rather to give the present status of medical opinion on the subject of Paranoia, than anything of especial novelty or originality. The writings of many recent authors have been freely drawn from and I make acknowledgement in advance for the assistance derived from those of Krafft-Ebing of Germany, Seglas of Paris, Noyes of New York, Hurd of Michigan and others.

The term Paranoia, though not designating a wholly new disease, does define a group of symptoms and reduces to something like scientific accuracy, knowledge which heretofore has been somewhat scattering and ill defined. The term monomania has been so widely and differently used in medicine and so abused by the laity that, limiting the conditions which it was meant to classify, the term Paranoia has been adopted after a certain process of evolution in its selection, as a fit term which shall not carry with it any of the mistaken ideas which would cling to the old. The very etymology of the old term monomania carried with it an idea which most alienists sought to avoid, viz., that the insanity was only partial, or in popular words that these people are only "crazy in a certain direction," properly sane in all others.

The grain of truth which is found in most *popular* conceptions of medicine, caused the term to be retained even by authors who, however, frequently explained it in their own way and apologized for the use of it. The false position taken, however, is amply demonstrated when we look at the lengths to which this conception of the disease went. If a certain definite disease was represented by the prominent delusion, why, naturally, there were as many diseases as delusions, and nomenclature ran riot. For instance we have pyromania, a desire to burn, kleptomania, a desire to steal, dipsomania a desire to drink, and gammomania, a desire to marry, and even the German "frauenschuhstehl monomanie" or mania for stealing women's shoes. The absurdities to which this ran led to a revulsion of feeling, a more thorough study of the disease these terms meant to designate, and finally a giving up of the name monomania. Furthermore these trivial distinctions indicated were often another name for vice and criminality and tended to confusion and lessened confidence in this branch of medicine.

Much has been written on Paranoia within the past eight years by French, German, Italian and English authors and there is still much difference as to the limits and subdivisions of this disease.

The Germans, however, have taken the lead in the study of it and Krafft-Ebing has been foremost in its demonstration. His views have been endorsed by many English and continental writers and I believe now represents the stand taken by many if not most leading alienists. Mendel, Meynert, and Leidesdorf, agree as to certain essentials though differing in minor points. After a most thorough study of the vast recent literature study of the subject, Dr. Seglas of Paris, as translated by Dr. Noys of New York in a series of articles recently appearing in the *Journal of Nervous and Mental Disease*, concludes that "there is one fact that stands out prominently, that all authors admit a form of primary Paranoia engrafted on a soil of degeneration and the existence of which is indisputable" but on subdividing, nomenclature etc., there are differences.

All chronic insanities with fixed delusions were thought to be invariably preceded by some active period of brain disease, either of violent mania or active melancholia, notwithstanding the fact that it was often difficult to find that such period of acute disease had taken place. A more thorough clinical study has demonstrated that many of these cases have been very gradual in their onset and development and in fact had defective brains from the beginning; were the crooked growing of a twig bent out of shape when very young or never healthy. This study assists us in deciding as to many puzzling cases, and the following definition of Paranoia in the new light, quoted from a recent author (Hurd of Michigan), is quite generally accepted: "that it is a form of mental disease which is developed in a defective brain or at least in one congenitally predisposed to take on diseased action. Its essential characteristic is the presence of delusions which rise without any antecedent emotional disturbance and are not elaborated by any intellectual process. It differs from other forms of mental disease by not terminating in incoherence or dementia and for many years the patient retains the ability to think logically."

The predisposition may be induced by ancestral epilepsy, inebriety insanity, etc, and may be acquired in the many infantile troubles which affect brain nutrition. The "blot on the brain" may be little noticeable for a long period until the growth of years or some somatic change develops peculiarities into marked eccentricities, evolves actual lunatics from "cranks." The exciting causes may be puberty, the climacteric, masturbation, typhoid fever or in fact anything which depresses the general health.

The evolution of his delusions until the patient finally turns up in some insane hospital is of great interest and often follows well marked lines.

For instance, the boy with early epilepsy, meningitis or scarlet fever grows up peculiar and different from ordinary boys; is of inferior physical or mental development, shows unnatural taste in study or play, begins to masturbate early, soon become seclusive, hides from others, thinks he is being watched and later believes he is being persecuted and haunted, until finally by some turn of the mental mechanism he acquires the idea that he is persecuted from envy, that he is in reality a genius, a great personage, or the heir to great property of which designing relatives desire to dispossess him.

This line of crooked development proceeding without check, frequently after a period of depression, confusion and uncertainty, fixes on certain delusions, viz. that he is in *reality* a great personage, inventor, king or even deity itself. These patients not rarely do some violent act in supposed defence of their rights or in indication of their divine mission, and their career thenceforth is continued in some asylum. They are the kings, inventors, poets, Napoleons, etc., of asylum wards, who are capable of much coherent talk and correct reasoning, who were considered "crazy only on one topic," but in whom the fact that their delusions, few though they may be, dominate their whole life and control their mental action, disproves the correctness of the term monomania. The predominent delusion, however may be one of exaltation. They may fail to get beyond the point of great depression due to their supposed persecutions, though they believe them to be unmerited and from envy, and in this they differ from true melancholia, in which the patients imagine they are persecuted because they *do* deserve it, that they are miserable and wicked, and not great persons at all but rather incumbrances to themselves and others, to whom suicide offers the only hope of relief.

It will be observed that these patients usually develop hallucinations or illusions of sight or hearing at some period in the course of their disease. They hear voices telling them of their divine character or mission or misinterpret the ordinary motions and gestures of people on the street as having direct reference to themselves or as signs among their enemies. Coughing, shuffling of feet, limping and a thousand other incidents of every day life convey to them some deep and hidden meaning or threat, which may lead them to some violent act in imagined defense or retaliation.

Dr. Spitzka relates a case here which he calls Paranoia and which at all events illustrates the foregoing:

"Dubourgue, the Fourteenth Street assassin of New York, inherited from his father cranial deformity. His father possessed the delusion that the United States government withheld from him several millions of dollars which he thought he had inherited from an uncle. The son possessed the same delusion, and heard as a child that the neighbors proposed poisoning him, the heir to this great estate. While at work painting a transatlantic steamer, after his father's death, he heard remarks by his fellow workmen to the effect that now the older claimant was dead they would waylay him that night and thus exterminate the family of heirs. On three occasions he stabbed persons who, he alleged, were pursuing him and crying out to kill him. On the second occasion, that of stabbing a police officer, he told so plausible a story that the magistrate discharged him. On the last occasion, in daylight, he started down Fourteenth Street while ladies were shopping, and ran down the street stabbing indiscriminately with an artist's compass. It is not known how many were stabbed—three at least dangerously and one fatally. He said he heard the cry on all sides, 'There goes the man who is going to take all that money out of the land; kill him,' then he drew the weapon to defend himself."

Two other groups of paranoiacs may be mentioned, viz., those whose mental twist and development have been in the direction of religious exaltation, who beginning with a weakened brain and a lessened power of self-control are carried away by some religious excitement to which they weakly yield, and in whom this is the starting point of delusions, which finally lead them to some overt act which causes their condition to be recognized and their commitment to some asylum. I recall the case of a patient now known to me who, two weeks since, was arrested for ascending the pulpit in a Toronto Church and insisting on expelling the false prophets and being heard himself, the only true representative of God on earth. This delusion of divine power and greatness he carries with him all the time. It is at times less prominent and more under control but crops out at varying intervals, completely controlling his life. Thus he worked for some weeks at LeValley's shop in this city, but finally broke out again, trying to appear on the stage at the Court Street Theater, to avenge an insult to Queen Victoria, whose agent he claimed to be.

Though never a patient at the Buffalo Asylum and known to me by only the slightest acquaintance in another state, he yet has an uncomfortable habit of turning up at the Buffalo Asylum to show me that his enemies, envious of his great and divine power, had not yet succeeded in getting him out of the world.

Another variety of paranoiac delusions has been called the erotic, in which the feeble, neurotic youth or maiden, early given to masturbation, sinks into a listless, dreary state of adoration for some ideal they have themselves created. This mental state, if continued, is apt gradually to fall into a condition of actual insanity, in which hallucinations of sight and hearing lead the patient to believe they have supernatural visions and conversations with the object of their adoration even though dead. Should the delusions fix on some individual, some outrageous act perpetrated for or against him or her usually unmasks the mental state of the patient. In women this warped mental attitude may result in fixed delusions of an exalted character, such as that they are the Mother of God, have intercourse with saints, etc., a state which has been called a condition of "spiritual prostitution."

These are the leading characteristics of the disease we are considering, but I feel that perhaps the points of difference from former ideas of monomania and its claims to a distinct and separate recognition have been too feebly set forth. The main distinction from other chronic insanities lies in the fact, which closer clinical study appears to bear out, viz., that they begin *without* previous active violent emotional disturbance, in brains congenitally defective or injured in early infancy. That they run a more even course than acute or chronic mania. That the patients possess more mental power and coherence, more ability to reason logically though from false premises, than patients suffering from chronic mania, the only disease with which some alienists claim this to be identical.

The termination is furthermore not in the state of such marked and complete dementia as in chronic mania.

The prognosis in those cases is bad; in fact the time when care and treatment can avail the most is in the early development of the patients, and consists in averting the catastrophe rather than in curing the established disease.

The utmost care of the mental, moral and physical surroundings of the child who has a bad family history of neurotic disease should be enjoined by the family physician, who alone is likely to have an opportunity at this stage to advise. Especial care in the diseases of infancy and at the age of puberty should be enjoined.

It is said by some writers that cures may sometimes be effected by active and prompt measures at the period of mental confusion, hesitancy and doubt which precedes the development of the "fixed" systematized delusions. Thus the patient who imagines himself persecuted and reviled in a hundred ways, is mentally groping in confusion for some explanation, while the trouble has progressed until he finally develops the idea that it is because he is a King or Prince. This delusion then becomes fixed and this is called the stage of transformation. After this occurs the prognosis is then unfavorable. Spitzka, however, considers John Bunyan a case of paranoia and states that he recovered even after this period had been long passed.

Some have felt that the acceptance of these views of Paranoia only enlarged the boundaries of insanity, and in so doing encroached on those of vice, and have hesitated to accept them. Should one of these cases, however, be brought to the notice of some family physician before a criminal act had been committed, we think there are few physicians who would deny that they are at least proper cases for medical treatment. Their recognition as such, however, does not necessarily commit us to the view that they are therefore irresponsible. They are in fact the very cases who linger so long upon the border line of insanity, and are often, unfortunately, long in crossing.

They are the cases who trouble courts and experts and whose very mental brightness renders their mental crookedness less noticeable. Before the development of fixed controlling delusions it is probable that most, if not all, have sufficient acumen to know the nature of their acts and sufficient control to refrain from doing a wicked one. It must be remembered, however, that a life-long history must be obtained and grounds for belief in insanity other than the commission of some one overt act, otherwise we should fall into the error of the old believers in monomania. It is well to keep in mind the healthy thought that without any other evidence of insanity dipsomania is merely another name for drunkenness ; pyromania for arson and kleptomania for stealing. In fact the reason for the avoidance of such one-sided terms it has been the object of this paper to show.

SURGERY OF THE KNEE-JOINT.

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[Read before the Buffalo Medical and Surgical Association.]

It is not my purpose to consider all the surgical diseases of the knee-joint. This title was chosen solely on account of brevity. I wish to relate some of my own experiences with this joint, and particularly to notice the great improvement made in treating it. And first, allow me to recall to your memory some points connected with its anatomy, which have been the cause of so much disaster to our profession throughout its entire past history, for, apparently, no real advance in the methods of treating a suppurating knee-joint, and the causes which produced it, had been made up to the time of my pupilage and early years of practice. The knee-joint is the largest in the body. Its synovial membrane has about one hundred square inches of surface, and including the large bursa under the quadriceps extensor muscle there are at least two hundred square inches of tissue which is liable to be converted into the lining of an immense pus cavity. This of itself is formidable enough to contend with, but the difficulty is greatly increased by the fact that the cavity is divided into three, by peculiar anatomical features. The synovial cavity proper is constricted at the level of the patella by a fold of synovial membrane, called the *ligamentum mucosum*, which extends from the patella backwards to the intercondyloid notch and forms an incomplete diaphragm, and this can be made almost complete by bending the knee and forcing the patella down into the notch. While this closure is sufficient to prevent the passage of fluid to the upper portion of the sac, it offers no barrier to the occurrence of sepsis. Connected with the upper sac, which itself extends a considerable distance up along the front of the femur, is the large bursa which forms the third sack already mentioned, and this, in a state of suppuration has been found to reach well up to Poupart's ligament. The opening of communication between these two upper cavities is often small and never is free and direct enough to allow proper drainage or cleaning from one to the other. * It also offers a direct route to septic material, and on account of the large amount of areolar tissue around it and in it offers a peculiarly rich field for the process of suppuration, once the germs which produce it have gained access. Considering this anatomical arrangement, it is not difficult to understand why our efforts in the past have been of so little effect, without the knowledge we now have of the causes of septicæmia, and the methods which are absolutely certain to prevent it, or if present, to control and finally destroy it. The wonder rather is that anyone with a suppurating knee-joint in all three of its cavities ever escaped.

The first serious knee-joint injury that I met in practice was in the winter of 1870, when Surgeon of Police. A man had been shot in the knee with a pistol. I found him sitting by the stove in the station, to which place he had been able to walk after the accident, without much difficulty. An examination showed only a small hole just below the patella, and, according to the teachings of those days, I introduced a probe, probably alive with all sorts of septic bacteria, and found that the ball had entered the joint. There was no swelling, very little pain, and to a layman the man was apparently but little injured. I, however, told the officers that it was a fatal wound, as the man would die. This prognosis, which would not be true to-day, was made as a result of my teachings, and what I had observed clinically as a student. The man was put into a carriage or on a drayman's wagon, for we had no ambulance in those days, and taken to the old Sisters' Hospital. Dr. Miner was on duty there, and, I need not say to those who knew him, the best surgical judgment and skill, of the time, were at the man's service. The knee was exsected; as a matter of course septicæmia followed. As a last resort the thigh was amputated, and the man died. The fault was not with the surgeon, nor the hospital, nor the attendance. No one else would have done better in those times. The trouble was that the knee-joint was poisoned as well as wounded, and although the bullet was removed together with injured tissues, yet the potency of septicæmia, pyæmia and the almost sure death of the patient, was not removed,but, on the contrary, were added to in every move of the surgeon and his assistants. The instruments, together with those using them, were surgically unclean. The vicinity of the wound was the same, and the dressings added to the already plentiful supply of septic material, were admirably adapted to keep it in after it had got into the wound. The criticism that should be made of the management of this case is obvious from what I have said, and, of course, should not apply to those in charge; but if at the present time a similar case should receive similar care, it would not be far out of the way to say, that a surgeon who would neglect the most rigid antiseptic precautions of the operation and after treament of an exsection of the knee-joint, for an accident of this nature, would be guilty of a degree of malpractice, which would approach very closely to manslaughter.

I have had three cases of exsection of the knee-joint under my care at the Buffalo General Hospital, where all of the cases I shall mention were treated, and, I wish to say, that it is not my purpose to minutely report any of them, but only the more prominent features which they presented. The operation was made in all for scrofulous disease or white swelling of the joint.

The first was a child five years of age. This age is the limit laid down in the books, for if younger it has been found impossible to control them sufficiently to get a good result. There were sinuses running down to the joint surface, and the leg was flexed strongly on the thigh and anchylosed. The tibia was not dislocated backwards as is commonly seen in very advanced cases. The joint was opened by the single straight incission across its front below the patella. A butcher's saw, with the blade turned upward, was used to make the incission through the bones. They were not cut squarely across at a right angle with the shaft, but were sloped in opposite directions; the slice from the femur being thin behind and thick in front, and included the patella which was united with it; while that from the tibia was thick behind and thin in front. The advantages in this method of removing the articular surfaces are, that the whole of the epiphyses is not removed either in front or behind, as they vary in thickness exactly as the incissions are planned, and, as a result, the further growth of the bones is not arrested as would be the case if it was entirely removed. A second advantage is that on account of the obliquity of the cut surfaces they are more easily kept in proper position during the after treatment. In fact, in none of the cases was there any trouble in this respect, which I judge must be the case when the cut is made straight across, from the fact that so many means are mentioned in the journals lately for the purpose, such as ivory pegs, nails, plain and plated, silver and iron wire, etc. The muscles soon contract and bring the surfaces, which are roughened from the sawing, firmly together, and very simple means will retain them there. After the use of the saw, the cut surface of the tibia showed two suppurating points, as though not enough of its substance had been removed to include all of the disease. It is not necessary, when this is the case, to repeat the incission, for the cases do perfectly well if the focus of softening is removed with the sharp spoon or gouge. The leg was now straightened out and it was found that enough bone had been removed for the purpose

A drainage tube was passed across the back of the joint, the soft parts united by sutures, and after all necessary antiseptic precautions in cleansing and dressing had been taken, the limb was put in an Ashurst's wire splint, devised for the purpose, which answers the indication well. The recovery of the child was uninterrupted, with only the usual care of the wound, and she left the hospital with a stiff leg an inch shorter than the other. Being only about enough shortening to facilitate the act of walking with a stiff knee-joint.

The second case was a young man 22 years of age. His condition was the same, and the procedure was the same as in the child. He recovered with a joint not entirely stiffened, but with considerable motion, so that the function of the leg was to a great extent restored.

The third case was the worst one and it would be difficult to conceive of a condition of tuberculosis of the joint more pronounced. The boy was 17 years of age, of a tuberculous history, and the disease had existed many years. He was placed in the hospital by his father, who was a statesman from the first ward, for treatment limited to any operation that might be thought necessary other than amputation. But here the line was strictly drawn, under a threatened penalty of suit for damages, and in addition, of personal violence to the operator and all who aided or abetted him. As a general rule, I think that a surgeon should refuse to make an operation on these terms, but in this case it undoubtedly kept me from finishing the exsection by an amputation at the lower third of the thigh, and gave to the boy a really useful leg.

This was what my colleague, Dr. Mynter, who kindly assisted me would call an arthrectomy, rather than an exsection, or it can be considered as an exsection with the addition of the essential feature of an arthrectomy; that is, the removal of the diseased capsule of the joint as well as the diseased bone tissue. It seems so reasonable and so much a matter of necessity that all diseased tissue should be exsected from a diseased joint rather than a portion only, that it is a wonder to us now that the thing was not done from the earliest history of the operation. But the fact is that our text-books do not even mention it. An arthrectomy may also be made where the capsule alone is diseased, and in this case the bones entering into the formation of the joint would be left intact. I have never seen this condition of things, however, in the knee-joint and think that it rarely exists. It is met with in other joints. In addition to the usual sinuses running down to the joint there was one which opened just above it on the inside of the thigh and extended upward into the femur, and at the upper extremity of the sinus was another, opening at the junction of the middle and lower third of the bone. A probe passed into either of these openings struck dead bone. The usual straight incision was made and the articular extremities removed, as before described. The capsule of the joint was then entirely removed with the scissors, the arthrectomy feature of the operation, and the incision prolonged at its inner extremity to the opening of the thigh sinus. On opening this more freely and removing some bone around it we were enabled to extract a sequestrum from the femur, about five inches long, and it was then seen that the opening at the lower third of the thigh communicated with the place of lodgment of the sequestrum by means of a hole through the shell of the femur. By this time in our dissection we had denuded the lower end of the femur of its soft parts so that it projected through the wound six inches with the leg hanging to the soft parts below. At this point it seemed to me that an amputation would most fittingly conclude our attempt to make an arthrectomy with exsection. But as we rested under an injunction in this respect, that we thought prudent to observe, we replaced the flesh around the femur. made ample provision for drainage, dressed it antiseptically and applied an Ashurst splint. There was considerable suppuration during the after treatment, due to our inability to remove all diseased tissue. and the recovery was slow but at no time dangerous to the life of the patient. My term of service at the hospital expired, but my colleague. Dr. Park, who succeeded me, kindly insisted that I should continue my care of the case because of the interest that I had taken in it. This I gladly did. During the healing process several small abscesses formed and were evacuated. Owing to a considerable degree of tension, the condyles of the femur caused, by pressure, a necrosis of the soft parts covering them, and when the slough separated they were both exposed. No harm came from this, as I feared might be the case. for granulations quickly appeared and closed over the protruding processes of bone. Just before Christmas, about six months after the operation, the boy left the hospital walking on a good, though stiff, leg.

From my experience with this boy, I can hardly imagine a case of scrofulosis of the knee-joint so severe, and the disorganization and distruction of tissue so great, but that an attempt, at least, should be made to save the limb by exsection with removal of the capsule.

I have had also three cases of general suppuration of the joint. The cause in all these originally was an incised wound, made by an ax, and all happened to choppers in the lumber districts of Pennsylvania. In two of them the wound was on the inner side of the patella, and in the other on the outer side. They were all treated in the same way. After the accident they were taken to their homes and a doctor called. Without any attempt to make surgically clean the wound, its vicinity, or his own hands, he sewed it together with the usual infected needle and silk, and applied dressings of the same nature. Now it was almost certain that the joint would become infected, and, if so, suppuration must take place within it whether the original clean cut healed or not. And this state of things did happen. In two of the patients the wounds healed by adhesion, but in one it did not. Suppuration occurred in all at about the same length of time after the accident, and was soon followed by a chill and the other indications of septicæmia. Nature came to the relief of the two whose wounds had so readily healed, and opened them, allowing the escape of a large quantity of pus, with decided relief to them. It was not sufficient to cure them, however, for the pus producing bacteria were at work in all portions of the three great cavities of the joint. The drainage from one to the other was imperfect, and so the simple reopening of the wound was entirely inadequate, and the condition of septicæmia continued. The third case was in the same condition, though his wound did not at any time close. Upon admission to the hospital the joints were swollen and red, movement in the least degree unbearable, temperature between 103° and 105°, with a quick and weak pulse and the other symptoms usual in purulent infection. The treatment was the same in all. Under anesthesia a White's uterine dilator was introduced through the wound, and used for a probe as well as a tractor for drawing in drainage tubes. Openings were made by cutting through the overlying tissues to its point. The instrument was then slightly opened and the tube slipped over one of the blades, then closed and withdrawn into the joint cavity. The tube can be left just within it, or it can be withdrawn across it and out at the point of entrance, which in these cases was the original wound. Probably it is not usually necessary to pass the tubes through the cavity of the joint between the two openings, as drainage will be as well established if they have the inner end fairly in it. The only difficulty I have found is to prevent the tubes from being withdrawn when the dressings are removed. This is prevented by passing them through and securing each end by a suture or safety pin, and this was the method I chiefly used in these cases and with good results.

The tubes did not act as irritating bodies. In the case whose wound never healed, my dilator probe did not reach the upper end of the pus cavity until it had passed half way up the thigh. In the other two it did not reach so far, but in them the upper limit of the cavity was much higher than it should have been. Four openings seemed to provide for the drainage of the three cavities, and this number was accordingly made. It is usually consided that six are required and eight may be made with advantage when the whole joint is affected. They are placed in pairs, one about six inches above the patella for the upper sac, two immediately above it for the sub-patellar sac, two below it on each side of the patella, and two at the sides just above the hamstring tendons. I did not follow any special rule in placing the tubes. All I tried to do was to make sure that I reached the utmost limits of the abscess so that I could flood it with a germicide solution and have it drain out again. There is more danger in putting too few tubes in than too many, as they can do no harm. The joints were kept clean and dressed antiseptically, and for the comfort of the patients the limb was fixed to a posterior splint. The tubes were gradually withdrawn, beginning with those most superior and the cases were gradually cured; one with a very stiff knee, and the others with a small degree of motion. Without this free drainage and antiseptic treatment, the only assistance that we could have offered would have been amputation of the thigh, which, on account of the distance up the thigh to which the pus extended, would have produced a suppurating stump, if the shock of the operation had not been fatal.

A large number of cases of ordinary synovitis with effusion have been in the wards, and from various causes. Some have developed gradually without any known cause; others have been the result of violence, and others apparently were rheumatic in their nature. The only operation required, and it was made in all such cases, was aspiration with subsequent compression with a rubber bandage applied loosely. With a surgically clean needle and a clean skin there is absolutely no danger in the operation, and the relief is prompt.

I will only tax your patience further by relating one more case, chiefly because of several unusual features about it. The patient froze both feet and legs, and Dr. Park asked my assistance so that they should be amputated synchronously in reality, and thereby save time and the shock and exhaustion of two operations at different times. The stumps suppurated somewhat during the after treatment, due, probably, to the pyogenic bacteria having passed upwards in the intermuscular cellular tissue above the apparent limit of the pus. As a result, they were sore and tender to pressure — and to avoid the pain of the extended position, the patient kept them flexed during the process of healing. The result was that when healed, the stumps were bent at a right angle to the thigh and no amount of force could straighten them. After having been discharged and kept in the Poor House for a while, some young ladies interested themselves in his condition, and secured money enough to buy a pair of artificial legs for him. But the leg man could not fit his wares to stumps flexed as they were, and so he was returned to the hospital to have them straightened. A tenotomy of the ham-string tendons and a section of the popliteal fascia, it was thought, would meet the indication, but like many another theory, when put in practice it did not produce the result expected. What then was to be done to enable the man to wear his new legs? Dr. Mynter lent me his valuable counsel and assistance, as he was in some way mixed up with the young ladies who had bought the legs. We concluded to cut everything necessary down to the head of the tibia, and we would have cut that too if necessary to effect our object, relying on the moist blood clot method of Scheede to heal the wound we should make. An Esmarch tourniquet was wrapped around the thigh in the usual manner, and while extension was made on the stump, we cut, and continued to cut everything we came to, until the leg was on a line with the thigh. On taking observations, we found that we had severed everything in the popliteal space, excepting the artery of that name, and that probably escaped because of its deep position. Both popliteal nerves, the popliteal vein, fasciæ and tendons were all severed. The wound was wedge-shaped, with the base to the skin, and about four inches wide. The larger vessels were secured by catgut ligatures, and the tourniquet loosened temporarily, to see if the hemorrhage would be excessive. It was found that it would not be, and the tourniquet was again tightened. The wound was then thoroughly drenched with bichloride solution, then covered with protective, then bichloride gauze and bandage, then a large amount of bichloride cotton and lastly a starch bandage. An anterior splint was applied, and made firm with plaster of Paris bandages, and the tourniquet taken off. The wound immediately filled with blood and some soaked through the mass of dressings, but that was all.

The wound was not opened for four weeks, when it was found still aseptic, though somewhat odorous. Organized flesh filled the wound. It was redressed and the process of healing went on, nerve united with nerve, vessel to vessel, tendon to tendon, and so on throughout all the several tissues until the wound was entirely healed, and sensation and motion in the straightened stumps were restored. Both knee-joints received the same treatment, and the man, after several months, walked out of the hospital on his two purchased legs. The Scheede method required the strictest antiseptic precautions, for if septic material had entered, the whole thing would have been spoiled, and we would have only had a large suppurating wound, which, when healed, would have left the stumps still more contracted by the resulting cicatrix. This was the only method by which the object in view could have been reached. The recital of my hospital experience with knee-joints is now ended, excepting amputations, but as these cases are common and without any special interest, I will pass them by.

This brief narative of seriously diseased knee-joints, and the treatment employed, shows that in this class of cases we have made, as I have remarked, a very decided advance. None of these patients died, nor was their condition at any time so serious as to cause anxiety as to their ultimate recovery. It seems to me that, with the knowledge we now have of the proper methods of employing drainage and antisepsis, we are placed in a position to undertake the treatment of this class of cases with a confidence, and certainly a success, heretofore unknown to our art. Instead of standing by, day after day, utterly useless spectators of the march of our patients through the terrible ordeal of septicæmia and pyæmia, with their dreaded accompanyments, to death, we are able to do positive things, that we know will be followed by a positive result — the relief of our patients. We do not have to trust to luck, or hope that they may in some way or other recover, as is the case in our care of far too many of the diseased conditions that we are called on to treat. Similar advances have been made in many other directions in surgery, and while I fear that what we call the practice of medicine will forever be obscured by so much mysticism, uncertainty and lack of knowledge that stomach-aches, coughs and headaches will continue to be attacked on about equal terms by us, with sugar pills, roots and barks, the laying on the hands and prayer. Yet, I believe that the signs of the times indicate that in the near future, our profession, as regards surgery, will be placed on a foundation so sure, that it may be classed as one of the exact sciences.

ATONIC IMPOTENCE AND ITS TREATMENT.

BY HERMAN E. HAYD, M. D., M. R. C. S. ENG.

[Read before the Buffalo Medical and Surgical Association.]

In selecting the subject of my paper this evening, I was not unmindful of its difficulties; but, like many another old and hacknied subject, it grows in interest as time and science advance. A few years ago, but little was done for the relief of these cases of sexual degeneracy, but as the etiology and pathology of deep urethral reflexes was better understood, a rational and satisfactory method of treatment resulted.

In a general way we may say that impotence implies an inability to perform the sexual act; and may be due to constitutional or local causes; to physical or psychical influences; to the injection and long-continued use of certain medicines; in fact, to any cause which will lessen or annihilate the power of erection. Erection is a physiological act and is brought about by reflex influences—afferent and efferent impressions—which effect an increased amount of blood, and subsequent stasis of that blood in the trabecular structure of the penis. These impressions may originate in the brain by reason of libidinous and lascivious thoughts; in the papillae and end-bulbs of the penis by titilation of that organ; by reflex irritative influences in the spinal cord; or by the pressure and mechanical irritation of an over-distended bladder; prostatic inflamatory products, etc., etc.

Thus Gross has classified our subject into atonic, psychical, symptomatic, and organic impotence; and it is the former, most frequent and easily amenable form—atonic impotence—which I desire to call your attention to this evening. It is the variety seen most in vigorous young men, whose lives of dissipation and veneral excesses bring about lesions, which are the direct cause of this early impotence. The roue about town who spends most of his time, if not in high living, in toying for hours with women to gratify and appease his passion, is among the earliest victims. And the young man whose public life is pure and above unkind reproach and criticism, in fact, the quiet, respectful Sunday-school boy, who seeks the seclusion of his bedroom to clandestinely practice self-pollution is soon righteously punished by this form of impotence.

How do these various causes bring this about? And then we have an explanation of the pathology of this disease. There exist in the spinal cord various special centers; and among them the so-called genito-spinal, whose function it is to preside over the genital organs. The center may act either independently or in the consonance with the brain. We all know that in order to have a proper normal and equable discharge of nerve force, it is necessary to have the conveying, receiving, and transmitting media healthy; and if any one of these be unduly excitable, an erotic and facile, and perverted nerve impression results. It was Gross who first pointed out the causative relationship between an unduly sensitive urethra and impotence; and his experience has been verified by every one who has studied this subject. Donorrhoea brings this condition about, either by producing a stricture which has associated with it a hypersensitive mucus membrane, or it leaves as a sequela granular hyperaesthetic patches along the urethral canal. Excessive venery or masturbation bring about the same pathological lesions, by causing repeated congestions and consequent exfoliation of the epethelial covering, and organization of exuded inflammatory products. Thus we have in masturbation a most fertile source of organic stricture. A contracted meatus, a lithic diathesis, are likewise capable of the same mischief. Admitting, then, that there exists an unduly sensitive canal, and especially so, if this supersensitiveness is in the deep or prostatic urethra at the opening of the ejaculatory ducts, the lumbo-spinal center is subjected to a constant and continued reflex irritation, which renders it either unduly irritable or paralyzes its functions altogether; thus the orgasm will be either too precipitate—atonic impotence—or no orgasm can be effected—paralytic impotence.

Atonic impotence, according to Gross, is divided into three classes: 1st, Where the erection is imperfect, ejaculation too precipitate; sexual desire remains, intercourse possible but incomplete. 2d, Where erection is either so feeble that intromission is impossible, or is entirely absent; desire still remains. 3d, Loss of the power of erection as well as the desire for intercourse. Out of one hundred and fifty cases reported by Gross, one hundred and forty were examples of the first class; fourteen of the second, and five of the third. By referring to my own case-books I find I have had under my care thirty-three cases; twenty-eight were of the first class, and five of the second, and so far I have not come across a patient in whom absence of desire existed. Indeed, in all of my cases the most eager anxiety to stimulate what little passion and power remained, was that which made them most patient patients.

There are present usually more or less physical evidences of this disease, both subjective and objective phenomena; according to the degree of seminal drain which has been occasioned, either from the venereal excesses, or the nocturnal pollutions so frequently associated with this condition; depending as they do often upon the very lesions which cause the lessened virility. But there are also frequently seen special symptoms associated with the more marked forms of this disease; such as are referable to spinal exhaustion, *Backache or myelasthenia*, as it is technically called, has been a very common symptom in my cases. This consists of a dull, heavy, uncomfortable ache in the lower dorsal and lumbar regions, increased by exertion and accompanied by early fatigue. It is also worse after sudden changes of temperature. In some persons there is a feeling of cold while in others intense burning is complained of. It differs from muscular rheumatism, in that the various movements of the trunk are not incommoded nor painful. It is not improved much by change of position; and one of my patients in particular suffered very much while lying down. Others prefer the supine position, not so much to relieve the pain as that sense of fatigue so frequently present. Repeatedly have I known these patients to have worn plasters of belladonna or capsicum for weeks, relieved at once by the passage of a cold-steel sound. There is no pain upon pressure, thus differing from the spinal irritation of Hammond, which is due to anæmia of the posterior columns; and which he, and many other authorities, say does not exist unless spinal tenderness is, or has been present at some time. It is perhaps a congestion of the cord, since lying on the back not only increases the backache, but increases that tendency to nocturnal pollutions so frequently seen in this affection.

Sometimes it is referred most to the top of the head, or back of the neck, and with it the complaint of dizziness, tinnitus aurium, flushing of the face, headache, want of will-power and mind-concentration, irritability of temper, disturbed and unrefreshing sleep—in fact, a group of symptoms embraced by the term cerebrasthenia. Loss of appetite, impaired digestion, flatulence, constipation, palpitation of the heart and general symptoms of blood impoverishment are also met with.

Frequent micturition has been another very common system, and like the backache is reflex in origin. It may be very distressing on account of its frequency, and the tenesmus present, or be hardly noticeable unless the patient's attention is called to it. I have observed this condition very frequently, where practically no stricture existed, and was due to the presence of sensitive patches in the urethral canal; and was cured permanently by the passage of a sound at varying intervals.

Precipitate ejaculation, as we have said, constitutes one of the prominent features of the disease, and is sometimes accompanied with pain and discharge of blood. This hemorrhage is due to the rupture of one of the deep urethral vessels in the engorged mucous membrane, or in the ejaculatory ducts. The patient may enjoy the power of erection, but be unable to copulate, either because the orgasm is too precipitate, or because the power of erection fails him, so as to make intromission impossible. In two of my cases, I believe this condition was largely psychical; because from frequent unsuccessful attempts at coitus undue anxiety and fear of possible failure at the time made penetration impossible.

Nocturnal pollutions, as well as diurnal discharges are often complained of. These day losses are occasioned by slight exercise, or the titilation consequent upon shaving, or other little acts, which require the exercise of will and forced quiet. I saw this condition once in a man who was compelled to let his beard grow, because the manipulations of his tonsorial artist brought on this distressing symptom. Let me give you a history of a few of my cases, and that will make the subject of treatment more interesting.

S—, a vigorous, plethoric man of forty, anticipating matrimony, called to see me on June 3d, 1885, and said he was suffering from an inability to perform the sexual act satisfactorily. He was a man of education, had traveled largely and in every way had enjoyed the world, and particularly the female element of the community. In his boyhood days he practised self-pollution somewhat, and at the early age of sixteen enjoyed sexual intercourse. From that time on he was addicted to all kinds of excesses; frequently visiting from one to three women a day. He apparently retained his general muscular vigor as he was the picture of health, but from the time he was thirty-five, he felt his sexual powers waning. He had just as great an appetite as he had in his youth, but could not consummate the act. While toying with a woman would have an orgasm, or while attempting intercourse would complete the orgasm before an entrance was possible. He remained continent for four months during his engagement, and then, so as to satisfy his mind, called upon a familiar mistress to find out what his powers were. To his disgust and surprise, he found himself no better, so he then sought medical advice. He had had gonorrhoea frequently in his youth and early manhood, but had never had orchitis nor syphilis. I at once instituted a physical examination, and found the testes firm and healthy. He had a contracted meatus, which I slit up, and then passed an exploratory bougie. At three and one-half inches from the meatus, I encountered a very sensitive stricture, calibre No. 18 French, while the posterior urethra was so excessively sensitive when I passed beneath the pubic arch that he fell on the floor in an epileptoid convulsion. He remained unconscious for a few minutes. I sent him home in a carriage, and advised hip baths as hot as could be borne, every third hour; gave him an opium suppository and prescribed the following: Tinct. canthar. m. i.; pot. brom. grs. xx.; tinct. cannib. indicae m. v.; tinct. gelsem. m. v.; every third hour; low diet and rest. This treatment I continued for seven days, exercising care to keep the meatus open. On the following day I gave him quiniae bi-sulph. grs. xv., and six hours afterwards injected a four per cent. solution of cocaine into the urethra and passed a soft bougie into the bladder. He still complained of much pain, but had no convulsion. On the third day I passed the same bougie, and at intervals of forty-eight to seventy-two hours passed a larger bougie, until finally I was enabled to use with little pain a No. 20 English steel sound. I then lengthened the period up to twice a week, and after four month's treatment advised him to marry. Before settling down, as he said, to the inevitable, he again visited his old friend and to his delight enjoyed his relations satisfactorily. I enjoined moderation during his marital life, and so far, now twenty-eight months, he has been well and happy. In the meantime I delivered his wife of a girl.

Another case, S. B., æt. 32, married four years, came to me complaining that he had never been able to have intercourse with his wife, the orgasm being too precipitate. He had never had gonorrhoea nor syphilis; in fact, never attempted sexual intercourse until married. In his youth he practised self abuse excessively, and at one time his family sent him away on account of ill health, which he attributed to these practices. At the age of twenty-four, he married a strong, healthy young woman, whom he had never enjoyed sexual congress with. Upon examination I found the genital organs well formed and the meatus admitted a No. 28 French without any difficulty. About two inches from the meatus I detected a very sensitive spot and at five and one-half inches an irritable stricture, calibre No. 16, and the deep urethra was abnormally sensitive. I commenced to pass sounds regularly at intervals of seventy-two hours; then every twenty-four until all pain and tenderness disappeared, and gave him a pot. brom. mixture grs. xx ter in die, to quiet his sexual appetite. After some ten week's treatment I advised him to attempt his conjugal relations. He did so, but complained that it was impossible to consummate the act, perhaps not from any fault on his part, but that of his wife. I directed him to bring her to me, and upon examination I found a very tense, excruciatingly sensitive hymen. Although perforated, it was in a condition of extreme rigidity, in fact she was suffering from a pronounced vaginismus. She was much run down physically; was pale, anæmic and irritable; and presented a picture much like those cases reported by Goddell in his book, in the chapter on conjugal onanism and kindred sins. I made a few lateral incisions though the hymen and forcibly dilated it. I met the husband a few days ago when he told me his marital relations were satisfactory. The case was extremely interesting, since I found a reasonable explanation for her debility, as well as the cause of his continued sexual excitability.

P., aet. 53, always healthy. Was married when twenty-four, and is the father of a large family. During his early manhood and married life, he was addicted to great sexual excesses. Would often visit three women a day. He had gonorrhoea frequently, but not syphilis, nor had he ever had orchitis. About three years ago he found he was unable to have intercourse—in fact could'nt get an erection; although he resorted to various stimulants in the way of different women, to bring about the desired result. He was of strong physique and evidently full of physical vigor. The genitals were well formed. I passed an exploratory bougie and found the urethra excessively sensitive along the whole tract, but especially under the pubic arch. There were two definite strictures; one 2¼ inches from meatus, calibre 23 French, and a second at the bulb, calibre 20 French. At intervals of twenty-eight hours I passed a steel sound—progressively larger—until the urethral canal was thoroughly dilated as well as relieved of its supersensitiveness. He was soon encouraged, because he noticed in the mornings a semi-erectile condition of the penis before micturating. This tension gradually increased and in the course of five weeks had a firm, strong erection. I enforced absolute continence and interdicted smoking, which he was excessively addicted to. After the sixth sitting he remarked in a surprised tone that the back-ache he had suffered from for some years had all disappeared. I applied electricty to the spine and nates, and gave a pill—damianæ, strych. et nucis vom. three times a day. He grew rapidly better, and begged his marital privileges. This I denied, and in spite of my most earnest protestations he indulged his feelings after having been under treatment nine weeks. Much injury resulted, because he returned to his old condition, and notwithstanding the most assiduous attention on my part for the past three months, his improvement has been very slight. The case is interesting in that it shows how the nerve centers can regain their lost tonicity, and gradually increase in strength and usefulness, and by a sudden demand and over-discharge of nerve force, so paralyze their functional activity altogether, as to influence all future recuperative power.

The prognosis of this disease is quite favorable. The younger and more vigorous the patient, the more hopeful and buoyant his disposition, the more satisfactory will our results be. The more there exists melancholia and hypochondria, the less favorable the prognosis, for moral persuasion and hope are most potent factors in the successful management of these cases. Unfortunately, it is this class of suffering humanity who fall into the hands of vulgar, self-praising quacks, whose alluring advertisements and assuring promises please and pander to their yearning and unsettled minds. Therefore, tact is necessary for us to cultivate in the management of this class of cases, and as Sir. Lionel Beale says: It is not another name for humbug, any more than kindness and politeness imply insincerity.

The treatment is naturally suggested by the pathology of this disease. Remove all sources of local irritation; such as a long foreskin, a contracted meatus, an irritable balanitis, irritating piles, stricture; since these all increase and keep up local sensitive urethral patches. Tone up the general physical condition by tonics, good food, good air and exercise—if the local trouble be not too severe or too acute so as to contra-indicate exertion. Lessen the nocturnal losses as much as possible by advising a hard bed, light bed clothing, bathing the genitals every night with cold water before retiring, and avoid sleeping on the back. Often in these cases a combination of pot. brom., grs. xxx; fl. ext. ergotæ, M. xv; tinct. cannib. indicæ, m. v, is very serviceable at bed time. There is no remedy so universally useful as the regular passage of the steel sound; since it more than any other agent removes morbid sensibilites of the urethra. If the hyperaesthesia be very excessive, and the general nervous system extremely impressionable, it is well to controll this by hot sitz baths, rectal injections of hot water, sexual sedatives as well as alkaline diuretics. Before instrumenation I always inject about twenty drops of a four per cent. solution of cocaine muriate, and if I have any reason to expect a urethral chill, or a convulsion to follow, I give about grs. xx. of quiniæ bi-sulph. about six hours before the seance. Deep urethral injections of argenti nitras, grs. x. to 1 oz., have been very satisfactory in my hands, when the sound caused too much irritation. These injections I give once or twice a week, seldom oftener, and seldom stronger than 10 grains to the ounce of water. Electricity locally, one pole to the testes and the other over the back, along the lower dorsal and lumbar region. When the centres seem to have lost their tonicity, I give preparations of phosphorous and strychnia, and in all cases enforce absolute sexual rest. When the sexual instinct is so much diminished that desire brings no response, preparations of damiana, phosphate of zinc, iron and strychnia are indicated. In some cases I have thought decided benefit resulted from the use of a galvanic current, the negative pole in the deep urethra, and the positive alternately in the rectum and then along the spine.

REPORT OF A CASE OF PISTOL SHOT WOUND OF THE ABDOMEN.

In the Practice of Dr. E. M. Moore, Jr., of Rochester, N. Y.

BY GEO. W. GOLER, M. D., ROCHESTER, N. Y.

At 2:30 P. M. Wm. P., aged 47, weighing about 270 lbs., received a wound in the abdomen from a 38 calibre revolver, the ball entering half an inch above and an inch to the right of the umbilicus. The wound was received while in the act of arresting the assailant, and while the patient was in a stooping position, beneath the arch of a bridge on which both men stood at the time. The patient was not more than six feet from his assailant at the time of the reception of the injury. Notwithstanding the severity of the wound the patient seized his prisoner and threw him to the ground with such force as to fracture his leg, and there held him until assistance arrived. P. then got up without help and attempted to walk, but, after going a few steps, went into collapse, from which he slightly recovered on the administration of stimulants, complaining of great pain in the region of the wound. He was immediately removed to a house near by, and from thence taken in a wagon to his home, where he was seen soon afterward by Dr. E. M. Moore, Jr.

His condition then was: Pulse 125, respiration 24, and shallow; skin very moist, abdomen slightly tymanitic, pain severe and not localized. Before being seen by Dr. Moore he had had ¼ gr. morph. sulph., by the mouth, and ¾ of a grain hypodermically, in divided doses, and occasional draughts of brandy. The patient was ordered brandy, 1 dr. every five minutes. This medication only served to lower and strengthen the pulse slightly without materially affecting the respiration; pain much relieved.

The bullet was proven to have perforated the intestines, by means of compressed air. The apparatus used consisted of an ordinary cylinder in which air is compressed for use with the atomizer. A rectal tube was passed into the rectum through which air under pressure was forced, at the same time a glass funnel, with a tube attachment at small end dipping into a vessel of water, was pressed firmly over the abdominal wound. Air being turned on, it was found after a short time to emerge from the water in the vessel in bubbles.

On being informed of the fact that the bullet had perforated the intestines, the patient spoke of an operation, saying that he knew from what he had read of a similar case occurring in the vicinity ten years ago, that it was his only chance. He was, therefore, prepared for operation by increased stimuli and an additional ¼ gr. morph. Just previous to being anæsthetized his condition was: Pulse 116, respiration 28, passed voluntarily about a pint of urine, skin very moist.

At 10 P. M. the patient was anæsthetized by Dr. French, and transfered to the table were the abdomen was scrubbed, shaved, surrounded by wet towels, wrung out of sol. mercuric cloride, 1-1000, laid over rubber sheeting; and under thorough aseptic and antiseptic precautions the operation was commenced.

In the presence of Dr. E. M. Moore, Sr., and with the assistance of Dr. Whitbeck, P. M. Moore, Mulligan, and the writer. Dr. E. M. Moore, Jr., made the primary incision extending from two inches below the ensiform appendix to three inches above the pubes, exposing through two inches of fat the surface of the linea alba, which was split up with a probe-pointed bistoury, using the finger as a guide.

The intestines appeared congested and not collapsed. There was but little blood in the abdominal cavity. The bullet was found to have passed from above and to the right of the umbilicus, diagonally downward and to the left in the direction of the left iliac region.

The bowel was rapidly passed over from duodenum to ilium, the exposed portion being laid on and covered with hot flat sponges wrung out of Thiersch's solution. In all, thirteen perforations were found; five of the bowel, seven of the mesentery, and one of the omentum. But one point, at which there were three perforations, required resection, a portion, approximately two inches, being removed with mesentery, the part united with fine catgut, by the Lambert suture, and covered with a warm sponge. From these perforations, as well as from two others, intestinal contents exuded and were found lying on neighboring coils. All of the perforations, save the one requiring resection, were trimmed out, the bowel being held between the fingers of an assistant with a moderate degree of pressure to prevent the intestinal contents exuding the path, united by "base-ball" suture with fine catgut, and returned to the abdominal cavity, which was then washed out with Thiersch's solution 1-1000, and sponged dry. A drainage tube was inserted at the lower angle of the external wound. An attempt was made to bring the margins of the linea alba together with heavy catgut, but the strain was found to be too great, and it was abandoned. Deep sutures of heavy silver wire were then passed; this had to be given up for the same reason. The wire was removed and deep sutures with Tait's silk made, superficial ones of catgut finally closing the external wound in this way. A moist antiseptic dressing was then applied, and the patient removed to his bed. Time of operation, two and one-half hours.

At closure of the external wound the patient's pulse began to gradually increase in frequency, going to 135. Dil. alcohol 1 dr, et tr. digitalis m. xxx., were given hypodermically; the dilute alcohol being repeated frequently. Pulse at 3 A. M. 108.

The patient came out of anæsthesia, readily spoke to his wife, said he felt better, and then slept. At 6 A. M. he collapsed, and died about 8 A. M.

Post-mortem, 28 hours after death, by Dr. Mulligan, coroner's physician. Unfortunately the body had been embalmed, and the cavities of abdomen, thorax and pericardium injected. Rigor mortis present, pupils normal; suggilations of face, chest and neck. Punctured wound of enbalmer's trocar in left axillary space, and in median line about an inch below ensiform appendix.

Cavity of thorax: Embalmer's fluid present; slight pleuritic adhesions at apices of both lungs; calcareous deposits at apices of both lungs; hypostatic congestion of lower lobes of both lungs.

About four ounces of embalmer's fluid in pericardial sac, two trocar wounds of sac, corresponding to two similar wounds in the right heart wall. Pulmonary and aortic valves held water, anterior coronary artery slightly calcified, otherwise, heart normal.

Abdominal cavity: Large amount of embalmer's fluid present, and a little clotted blood that had been coagulated by contact with the fluid present.

Spleen normal, exhibiting a trocar wound. Kidneys normal. Adrenal bodies normal. Stomach congested, containing some watery fluid and mucus. Bladder holding about a pint of urine.

On removal of the intestines a careful examination showed that no wounded portion had been overlooked. The united surfaces of the resected protion showed agglutination, and were surrounded by a ring of venous congestion for about a quarter of an inch. After removing the greater bowel, which was found unchanged, the rectum was cut away showing on its left lateral surface about its middle a superficial abraison. On explorating the cavity of the true pelvis, a sinus was found in the lower margin of the obturator externus, extending to inner side of tuberosity of ischium, where it turned upwards in the direction of the ischiatic spine. The ball was found resting in this position at the end of the sinus. It would appear from this that the course of the bullet had been as follows: Entering at half an inch above and an inch to the right of umbilicus, passing downwards and to the left through great omentum and jejunum, escaping the bladder, ureters and trunk or branches of the iliacs, along in front of left side of rectum, to the inner surface of tuberosity of ischium where it lodged.

Brain normal.

A CASE OF MALFORMATION OF THE HEART.

BY J. H. PRYOR, M. D.

[Reported to the Pathological Society, March 15, 1889.]

J. W., aet. 6½ years. Born at full term. Until 3 years of age appeared healthy. Later signs of dyspnœa after exertion. During the past year dyspnœa with cyanosis occurred after walking rapidly or running.

January 14th the child fell from a chair at the table after a hearty meal; became unconscious, and remained in that condition for 15 minutes. Then he vomited freely but remained stupid and dull. Dr. Pohl was called and found an interesting cardiac lesion, which I was invited to examine. The chest wall showed a marked lift and thrill, and there was a strong pulsation of the carotids. The apex beat noticeable in the sixth intercostal space, somewhat to the right, First sound clear, but second sound almost entirely muffled by an intense, high-pitched murmur, which was mostly systolic, but also diastolic. The sound was audible, both anteriorly and posteriorly, over the whole chest; distinctly localized at aortic orifice. Pulmonary second sound absent, or inaudible on account of the loud murmur. Fingers clubbed. Headache frontal, intermittent relieved by recumbent position. Constipation; very dull and fretful when aroused from a drowsy state. Pulse 130; temperature 100°. Diagnosed malformation of pulmonary artery suspicion of endocarditis at aortic orifice; with also tubercular meningitis secondary changes from emboli. Tr. digitalis and pot. brom. were prescribed, and for some time he seemed to improve. Could not leave the bed or remain in upright position long without becoming faint and dizzy. The headache diminished and appetite returned. About the middle of February the headache grew worse and occasionally was excruciating. Heart acting better. Temperature ranged from 99° to 101°. Impossible to leave the bed. On the 27th complained of photophobia of right eye, eyelid of left eye drooping and pupils dilated. Gradual paralysis, never complete, of upper half or left side. Head-ache shifts from frontal region to occipital, and child cries out in sleep. Vomits occasionally. Mind clear. On the 29th, thought and speech slow and halting. Some words drawled. Temperature 101°. March 1st, Cheyne-Storkes respiration, intense headache; expresses himself intelligently. Died on the 2d. Autopsy same day.

Brain œdematous. Left lateral ventricle slightly distended with fluid. Encysted abscess of right hemisphere, frontal lobe, involving white matter. Cyst membrane contained about two ounces of greenish, thick, stinking pus. Surrounding area broken down with considerable grayish-black detritus. Heart greatly hypertrophied and especially the left ventricle. Right ventricle hypertrophied and dilated. Tricuspid valves stretched and insufficient. Near the interventricular septum a large pouch, partially separated from the rest of the ventricle by large columns of muscle. Interventricular septum incomplete at "undefended" parts. Pulmonary artery absent. Right and left ventricles both open into the aorta, which is pouched near the heart and enlarged. Aortic valves complete. No signs of endocarditis excepting slight reddening. The opening made by incomplete septum large enough to admit an ordinary sized little finger. On the free surface appeared a small, imperfect, rudimentary valve leaflet. Auricles normal. Foramen ovale closed. Conclusion: The heart lesion is of interest in connection with several debatable theories. Absence of the pulmonary artery with incomplete septum and both ventricles opening into the aorta, offers positive evidence to repute the inflammatory theory of congenital malformation so strongly urged by Rokitansky and many others.

In this case development was checked before any attempt had been made to divide the common trunk into aorta and pulmonary artery, which occurs early in fœtal life while the septum is forming. The argument in favor of malformation, due to incomplete development without inflammatory changes at the pulmonary orifice, seems unanswerable. The case is also of great interest in reference to the cause of cyanosis and its pathological meaning. The admixture of venous and arterial blood has long been accepted as a mode of production. It will be noticed that the blood from both sides of the heart commingled in the aorta, and cyanosis in any degree never appeared unless free exercise gave rise to difficult breathing. Thus the conditions seem to prove that pulmonary congestion, with stasis, lessened oxidation and rendered the blood temperarily venous. This symptom always soon subsided with rest in the recumbent position. It is impossible to state how the blood entered the lungs. The specimen was obtained surreptitiously and hurriedly removed. No opportunity was afforded to examine the vessels and learn the communication between the aorta and lungs. Other cases have demonstrated, however, that communication may be established by a direct branch from the aorta, which probably existed in this case, or by branches from the bronchial or mammary arteries much enlarged to carry the necessary supply. The loud murmur was caused by obstruction and regurgitation at the orifice of the opening in the septum, and also by the opposing indirection of the blood currents in the sacculated aorta. A study of compensatory changes reveals unusual efforts in this direction. The brain lesion is of special interest on account of the peculiarity and paucity of symptoms and its uncertain ætiology. The most reasonable explanation, and the one in accord with experience, renders it probable that a septic embolism, the result of an endocarditis, left the heart and lodged in a branch of the anterior cerebral artery. Thus far I have not been able to find a similar malformation reported. In cases of malformation death by some form of cerebral disease is common. Quite a number suffering from lesions as grave have reached an older age, and several have attained or passed middle life. A microscopical examination of the cardiac muscle or aortic leaflets has not yet been made.

THERE is a talk of applying telephones to the infectious wards of the French hospitals, so as to enable the sick people isolated in their contagious sufferings to have the comfort of hearing their relatives' voices without any risk of conveying infection by an intervew. It certainly is a very humane idea, and would not — one would think — be a very costly one to carry out; we commend it to the benevolence of some millionaire who wants to do a good deed, or wishes to perpetuate the memory of some beloved relative by a benefit to his suffering fellow creatures.

TYPHOID fever is rapidly coming to cause in current life the dread caused by small-pox a century ago, and the *Medical News* in its last number points out that the International Congress for Hygiene, at Vienna, reached the conclusion that bad drinking water had more to do with causing this disease than any other source of contamination. The evidence of this is all but conclusive, the solitary missing link being the identification of the bacteria of sewage-contaminated water and that of typhoid. The general evidence of a connection between a sewage-infected supply of water and a prevalence of typhoid fever is practically overwhelming.

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BUFFALO, N. Y., APRIL, 1889.

THE BACILLUS OF DIPHTHERIA.

Every real contribution to our knowledge of the etiology of diphtheria is increasingly valuable as we near the time, not distant it is hoped, when we shall feel towards this dread disease as we now feel toward small-pox — a terrible malady without vaccination; comparatively harmless with it. If we institute a comparison between the age, so to speak, and our present knowledge concerning the cause of any other disease we will see that the ideas of to-day, in relation to the cause of diphtheria, are relatively well advanced.

Since the true importance of the role played by micro-organisms in disease has been realized and appreciated, many attempts have been made to identify and demonstrate the bacterium of diphtheria. All possible localities have been searched without avail, and especially is this true of the earlier efforts. Investigations of the blood, kidneys, and other tissues by earnest and competent workers gave no results. Until Lœffler described his *bacillus diphtheriæ*, and provisionally assigned to it the causation of this disease, no one had laid the finger of conviction on any specific growth or material and proclaimed it as the source of the trouble.

Dr. G. M. Sternberg, in a recently published lecture (*Brooklyn Medical Journal*, March, 1889), gave a very interesting *resume* of our present knowledge of the *bacillus diphtheriæ*, and reviewed, particularly, the publication of Roux and Yersin (Annals of Pasteur Institute, December, 1888). To this lecture most of the following data must be credited.

Lœffler, for certain stated reasons, refrained from positively attributing to his bacillus direct causative relations, and quietly awaited confirmation at the hands of other observers, or from results of future personal work. He observed that the inoculation of a portion from a pure culture of this bacillus, on the surface of a previously excoriated mucous membrane, as the conjunctiva, vagina, trachea, or pharynx of guinea pigs and rabbits, produced a diphtheritic inflammation with the formation of a false membrane. In the above mentioned paper, Roux and Yerson say: "We must recognize that if the work of Lœffler has not resolved the question of the etiology of diphtheria, it has very well prepared the way for the study of this malady. It has served us as a point of departure for the research which we publish to-day, and which permits us to affirm that the bacillus of Klebs and Lœffler is the specific bacillus of diphtheria. In fact, we have found it in all (15) cases of diphtheria that we have examined. With pure culture of the bacillus we have, like Lœffler, produced false membranes in animals; but more fortunate than he was, we have been able to produce in animals paralyses analogous to those observed in man as a result of diphtheria. Finally we have demonstrated that the cultures of this bacillus contain a poison which, according to the dose injected, rapidly kills animals or induces in them paralyses in the absence of living microbes."

To obtain a pure culture the usual method is employed. A bit of the false membrane is inoculated on to tubes of solid blood serum, making several surface lines. Within a very short time numerous grayish colonies appear from which other tubes are inoculated, and so on until a pure growth results. The colonies appear early, very much before ordinary forms can be detected. If we introduce into the trachea of a rabbit a portion of such a pure culture, an intense inflammation ensues, the formation of a false membrane occurs, a marked enlargement of the cervical glands is noticed, dyspnœa supervenes, and death, as a rule, results. It is said, that these symptoms have a marked resemblance to those exhibited in pseudo-membranous croup.

Different observers claim that micro-organisms, other than the bacillus of diphtheria, can produce false membranes, and if this be true it vitiates, more or less, the importance of the induction of pseudo-membranes artificially. To offset this, Roux and Yersin call attention to the supervention of paralyses in those animals which have been subjected to an induced diphtheria. These paralyses, as has been previously stated, are strikingly similar to those seen in man after the true disease. One of their results exemplifying this statement is given as follows: "A rabbit inoculated in the trachea, after tracheotomy, presented on the second day dyspnœa, with noisy respiration. Later it improved, but on the sixth day it was observed that its posterior extremities were paralyzed. This paralysis was progressive, and the animal died. The lymphatic glands of the neck were found to be swollen and œdematous; the trachea was congested, but no longer contained false membrane."

Yet another point of more than ordinary interest is published. If a culture of the bacillus is passed through a porcelain filter (which is the only substance that will entirely sift out micro-organisms from a solution) and an animal be inoculated subcutaneously with a portion of the filtrate, which is *free* from any of the original or any other *microbes*, it is noticed that the animal, in a day or two, becomes ill, a bloody discharge comes from the urethra, respiratory difficulty shows itself, and the animal succumbs from e xhaustion. At the *post-mortem* every change is noticed just as in an animal dead from the inoculation with the ordinary culture, excepting that there is no formation of a false membrane.

Dr. Sternberg remarks in closing: "Finally I may say that the experimental evidence, with reference to the etiological role of Lœffler's diphtheria bacillus, is rather more satisfactory than that which has been adduced in favor of the relation of Eberth's bacillus to typhoid fever, or Koch's comma bacillus to Asiatic cholera, and that most conservative bacteriologists seem inclined to the view that it is, in fact, the specific infectious agent in this disease."

One is lead by this contribution of Roux and Yersin to speculate on many points relating to diphtheria, etc.

Are there two kinds of so-called diphtheria? It is a matter of common consent, that different epidemics are vastly different in many respects. In the one, perhaps, the great majority of cases recover, and in the other, a most malignant and fatal course is run with the loss of every case. For instance, in some recent statistics by Thiersch, of Germany, it is stated that he saved by intubation only three cases out of 32 of diphtheritic croup, and said, "He met with a run of malignant diphtheria in this series." In other words, there is a mild and a malignant type. Lœffler and Hoffman have also found in diphtheria a bacillus very similar to the *bacillus diphtheriæ*, differing, however, from it in not being so virulent. Perhaps this microbe may cause the milder variety. Or, perhaps, these cases are merely the result of a general sepsis with the formation of a pseudo-membrane. The observance of such a membrane does not prohibit this view, for as spoken of before, it is held by different observers that bacteria other than the bacillus of diphtheria can give rise to a membranous exudate.

The failure of early observers to find and demonstrate the bacillus diphtheria does not militate against the validity of the claim that it is the true cause of this disease. There are many points which explain this failure: the rapidity with which the bacillus grows gives ample chance for its being overlooked, and later swept away by the more vigorous growing bacteria; it has been shown that its habitat is principally in the deeper layers of the exudate, and it may thus have been missed by a superficial scraping of the membrane; the material for culture may have been taken late, at a time when the bacilli were all dead. We have seen that it is possibie for an animal to die from a dose of the excretions (ptomaine) of the bacillus alone, and it is easy, in view of this fact, to conceive how the bacilli may be dead, and yet the case terminate fatally; if the blood of an animal be examined for bacilli 16 hours after an intravenous injection of a pure culture of the *bacillus diphtheriæ* none can be found, though they are easily demonstrated six hours after the injection. The exact explanation of this last phenomenon is as yet beyond us.

The discovery of a ptomaine in the cultures of the bacillus of diphtheria forms one of the most important features of Roux and Yersin's work. It is strictly in the line of like communications made by other experimenters, as Brieger, Gautier, Roux, and Chamberland, ect., and will add one to a list which includes typhotoxin from the bacillus of typhoid fever, etc. All this is surely directing the stream of medical conviction towards the view that bacteria do not cause their peculiar and accompanying diseases by their presence alone, but rather by an accumulation in the system of their excretions, which we believe these ptomaines are, and which are toxic in an extreme degree. It seems to us that this is as clear a demonstration of the relation of a specific organism to a disease as that which exists between anthrax and the *bacillus* anthracis, and clears the ground up to the point where we stand awaiting the advent of means to successfully combat the germ and counteract its poison.

THE PRESENT STATUS OF INTUBATION.

Dr. Dillon Brown, in the *New York Medical Journal*, of March 9, 1889, reports the results of intubation on two hundred patients suffering from diphtheritic croup, with fifty-four recoveries,=27 per cent.

In this series of cases Brown demonstrates graphically that 43 per cent. died from extension to the bronchi, and 16 per cent. from sepsis, dividing more than a majority of the fatal cases between these two causes alone.

Other graphic tables given seem to indicate that; the more rapid the case the greater were the probabilities of its fatal end, and *vice versa*: when there was an absence of membranes in the pharynx or posterior nares the cases were inclined to be more fatal than in those in which the membrane was found in these places. From a large experience this observer holds that bichloride of mercury internally is the best remedy in the treatment of croup and diphtheria.

In the same article Dr. Brown also collates the records of 2368 cases of intubation occurring in the experience of 166 operators. These statistics were contributed personally to the compiler and are authentic.

Of 2368 cases 647 recovered,=27.3 per cent. A comparison between tracheotomy, and intubation by means of this collation and others bearing on tracheotomy, gives an exceedingly favorable view of intubation. An average taken from over 7500 cases of tracheotomy.

contributed by Cohen, Jacobi, Agnew, Waxham, and others, show that about 26 per cent. recover, leaving a margin of 1 per cent. in favor of intubation. Notwithstanding that the numerical difference is to be credited on the side of intubation, we still believe that the time is not yet when a proper comparison can be made. The conditions, at present, are such as do not tend to bring out the possibilities that we believe are important in intubation. When O'Dwyer's operation shall have been as well known, as widely practiced and as constantly in mind as is tracheotomy, then we shall see yet more gratifying results in its rise.

FORTY-THIRD ANNUAL COMMENCEMENT OF THE MEDICAL DEPARTMENT, UNIVERSITY OF BUFFALO.

The Forty-third Annual Commencement of the Medical Department of the University of Buffalo took place Tuesday, March 26, 1889.

At the morning session of the Alumni Association, and in the absence of the president, Dr. Harrington, the vice president, Dr. Shurley, of Detroit, called the meeting to order and introduced Prof. Stoddard, who delivered a well-timed address of welcome.

Referring to Dr. Talmage's plan for making converts to Christianity, Prof. Stoddard suggested that each alumnus make a convert to the cause of medicine, and in that way greatly increase the membership of the association.

The president's address was deferred till the afternoon session.

Dr. W. Scott Renner, graduate of McGill University, Montreal, now of Buffalo, was made an honorary member. Also Dr. John McPherson, of Akron.

The committee on prize essays reported through their chairman, Dr. Pryor, that no essay of those received had such merit of originality as to deserve the prize.

Dr. Callanan, of the class of '84, stated that his class had erected a memorial tablet to contain the names of the founders of the college, along with those of Drs. Potter, Eastman, Rochester, Hunt, Hadley and Miner. It would be found in the main hallway of the building, and would be disclosed during the afternoon.

Dr. Long, the necrologist, read the list of the dead for 1888 as follows: Fred. W. Sweetland, Angola; Donald J. Lathrop, Granger, Minn.; James A. Williams, Edwardburg, Mich.; Augustus R. Davidson, Buffalo; Harvey Jewett, Canandaigua; Fred. R. Campbell, Buffalo; Zara H. Blake, Dansville.

On motion of Dr. B. G. Long the executive committee were instructed to take under advisement the object of class reunions, and if possible to secure a reunion of each outgoing class every five years.

A nominating committee for officers for 1889 was appointed and reported the following names: President — E. L. Shurley, Detroit. First Vice President — Peter N. Wise, Ovid. Second Vice President — Eugene Smith, Detroit. Third Vice President — E. R. Hopkins, Silver Creek. Fourth Vice President — M. B. Folwell, Buffalo. Fifth Vice President — Alex. McNamara, Corning. Permanent Secretary — John J. Walsh, Buffalo. Recording Secretary — Eugene Smith, Buffalo. Treasurer — E. C. W. O'Brien, Buffalo. Trustees — D. W. Harrington, E. C. W. O'Brien, Buffalo, N. Y.; Horace Hoyt, East Aurora, N. Y.; Henry Lapp, Clarence, N. Y.; F. E. L. Brecht, Buffalo, N. Y. Executive Committee — F. W. Abbott, H. Bingham and W. T. Tanner.

At the afternoon session Dr. Shurley delivered his presidential address, which was mainly an appeal to the *amour propre* of the alumni in the direction of their own higher interests and those of their *alma mater*.

Dr. Frederick Peterson, of New York, read a paper on "Electric Cataphoresis, with Special Reference to the Employment of the Anode with Cocaine and Aconitia in Neuralgia."

Dr. H. R. Hopkins, of Buffalo, read a paper on "Dilatation of the Heart and its Treatment."

Dr. Irving Snow, of Buffalo, presented a paper on "Rachitis."

In ensuing numbers of THE MEDICAL PRESS we shall present these papers in full or in abstract.

Dr. C. H. Richmond, of Livonia, presented for examination a very interesting case of thoracic aneurism.

The commencement exercises proper took place at Music Hall in the evening. The large hall was well filled with an interested audience. The vice chancellor, Hon. J. O. Putnam, presided.

The degree of Doctor of Medicine was conferred upon the following class of forty-six:

Albon E. Bartoo, Eden.
Alfred Joseph Rutherford, Milwaukee.
Robert S. Carr, East Bloomfield.
Anna Wadsworth, Brockport.
William J. Zopfi, Buffalo.
James H. McCort, Rochester.
Jacob M. Kraus. Clarence.
Grover W. Wende, Mill Grove.
Leonard O. Eastman, Berkshire.
Frederick W. Kœhler, Buffalo.
William Stanton, Belfast.
Marrian A Townley, Ludlowville.
Patterson J. McNamara, Corning.
Henry Jones Mulford, Buffalo.
Augusta L. Damon, Canaseraga.
Robert W. Green, Geneseo.
George E. Dixon, Morris.
George W. Goler, Rochester.
Lorenzo P. McCray, Clymer.
Herbert A. Birdsall, Buffalo.
Louis A. Ball, Buffalo.
Allen A. Jones, Buffalo.
John Theron James, Medina.
Lyman C. Broughton, Buffalo.
Edward Whittier, Kendall.
Charles R. Jennings, Willink.
Alfred W. Henckel, Rochester.
Herbert Upham Williams, Buffalo.
John M. O'Brien, New York.
John R. Gray, Buffalo.
Elmer E. Briggs, Silver Creek.
Arnold Drexel, Mt. Calvary, Wis.
Samuel Huston Lynde, Buffalo.
Ammiel J. Thorne, Haverlack, Canada.
Lucius L. Ball, Buffalo.
John C. Brown, Smithport, Pa.
Harold A. Hayes, Tonawanda.
Katharine M. Bailey, Buffalo.
Walter S. Yates, Santa Barbara, Cal.
William T. Twitty, Warrenton, N. C.
Thomas Bagley, Buffalo.
William O. Burbank, Gaines.
Cornelius Mackey, Rushville.
John J. Drake, Buffalo.
William A. Ladd, Clarence.
Thomas B. Fernald, Norwich.
Walter E. Gregory, Dansville.

The honor roll was announced as follows: Messrs. Williams, Jones, O'Brien, Zopfi, Bartoo, Kœhler, Gregory, Henckel, and Dixson. Messrs. Williams and Mulford received honorable mention for originality and value of their theses.

The degree of Graduate in Pharmacy was at the same time conferred upon a class of sixteen, as follows:

John Ackor, Cleveland.
Edward Beckenbaach, Cleveland.
Henry George Bentz, M. D., Buffalo.
John F. Burkhardt, Rochester.
Salma P. Colgrove, M. D., Salamanca.
Samuel H. Dorr, Scottsville.
Russell Elliot, Buffalo.
Fred. J. Fairchild, Hammondsport.
Geo. F. Fuhrmeyer, Cleveland.
Fred N. Hutchins, Sayre, Pa.
William O. Jaeger, Buffalo.
Fred. S. Marsh, Lander, Pa.
Plin S. McArthur, Buffalo.
Meta A. Miller, Buffalo.
Emil T. F. Stark, Buffalo.
Lewis L. Trowbridge, Lewiston.

The address to the class was delivered by Prof. Ansley Wilcox, LL. B., and that to the Alumni by Prof. Geo. H. Fox, of the College of Physicians and Surgeons of New York.

Later the Annual Banquet was held at the Tifft House, from which the guests did not rise till nearly 3 o'clock. The toasts were the following:

"The Medical Faculty"	Prof. Roswell Park, M. D.
"The Clergy"	Rev. Pitt Dillingham.
"Journalism"	Edwin Fleming.
"The Army Medical Man"	Dr. L. A. Maus, U. S. A.
"The Ladies"	William C. Cornwell.
"The Legal Fraternity"	Prof. Ansley Wilcox.
"The Faculty of Pharmacy"	Prof. E. V. Stoddard, M. D.
"The Class of '89"	Alfred W. Henckell, M. D.

Altogether the college has every reason for congratulating itself upon the outgoing class and upon the interest and earnestness of its alumni. Ere long we expect to announce in these pages certain further steps in advance which should bring a feeling of joy and satisfaction to every loyal son of the Buffalo Medical College.

Society Proceedings.

BUFFALO PATHOLOGICAL SOCIETY.

REPORTED BY DR. EUGENE A. SMITH, SEC'Y.

Regular meeting, March 15th. The president, Dr. Park, in the chair.

Dr. Eli Long read a paper on "Intermittent Albuminuria." As the author intends to publish a later, and more complete article on this subject the paper is not given. He called attention to the uncertain nomenclature and pathology of intermittent albuminuria, and gave a full report of an instructive series of observations on a case under his care. In the discussion Dr. Park called attention to the author's painstaking work which he thought ought to be emulated. Dr. E. A. Smith spoke of the peptonuria which follows the ingestion of easily digested foods, especially rich soups. Here the albumen is precipitated at a lower temperature than serum albumen.

Dr. Pryor presented a rare specimen of malformed heart. Vide page 184.

Dr. Rochester presented a *ruptured liver* with the following history: An Italian in stepping from a train was struck by a passing engine and severely injured. Pronounced shock at once set in and was followed by death in three hours. Post mortem examination revealed seven ribs fractured on the right side, one of which perforated the pleura. The liver was found crushed and ruptured, with a piece weighing nearly a pound entirely separated from the rest of the organ. Examination before death had revealed the fractured ribs, but no external appearance suggested any injury of the liver. Dr. Hopkins reminded the members of the importance of the specimen from a medico-legal point of view.

Dr. Starr, a candidate for membership, sent the following report of a case of *irido-cyclitis,* with the specimen.

The patient from whom this specimen was removed is a man about 37 years old; the history, which is taken from my record, is this: "About 20 years ago his eye was injured at sclero-corneal margin, resulting in prolapse of iris, and the formation of cataract. Patient experienced no special trouble with eye until a year ago, when it inflamed, and a slight staphyloma of the sclerotic developed. The eye recovered from this inflammation and remained quite well until two weeks ago. Now there is marked cyclitis, and the staphyloma is increasing."

The condition growing worse, and symptoms of irritation appearing in the other eye, enucleation was advised. After removal, the interior was found to be completely disorganized.

Dr. J. S. Smith, a candidate for membership, sent the following report of a case of *immense meningocele,* with specimen.

On February 19, 1889, he used the forceps to deliver a fœtus which presented by the brow (occiput to the rear) owing to some fluctuating tumor of the head which prevented proper flexion. After the delivery the child was found to have a soft fluctuating tumor, the size of a large fist, attached to the back of the head by a peduncle about one inch in diameter. The child was small, but seemed otherwise well-formed and normal. The tumor was translucent throughout, and to all appearances was a fluid-filled sac, a meningocele, also called hydromeningocele.

Moderate pressure on the tumor did not affect the child. The pedicle being small Dr. Park removed the tumor on the day after birth by ligating the pedicle and cutting away the sac. No brain matter was found in the operator's way. The child seemed to feel no bad effects during the operation. But about an hour later it had a convulsion and shortly after another, in which it died.

A post mortem examination revealed the following condition: Cranial bones were widely separated, the sagittal suture being ¼ inch wide. The anterior fontanel was 2 inches wide and 2 inches long, making a large membranous space. The posterior fontanel was more normal in size. There were seemingly ossa triquetra (Wormian bones) taking the place of the right parietal bone, but later these proved to be bony ridges in the unossified membranous bone. The pedicle was found to be attached one inch below the posterior fontanel in the occipital bone, the opening in that bone being one inch in diameter and just at the site of the occipital protuberance. A probe passed into the cavity of the pedicle passed inward between two layers of the falx cerebelli and emerged above the basilar process of the occipital bone between the hemispheres of the brain. Upon using a blow-pipe the lateral halves of the brain were separated. The fluid in the sac must have communicated with the cerebro-spinal fluid in the subarachnoid space. The sac held, perhaps, eight drs., and was lined by a prolongation of the dura mater and arachnoid.

The cause of death was found in an arterial injection of the pia mater, due probably to change in cerebral pressure after the removal of the fluid-filled sac. The congestion was extreme and covered the surface of the cerebrum and the cerebellum. An extreme ecchymosis between the skin and pericranium over the forehead and anterior fontanel was due to the unabsorbed caput succedaneum.

Dr. Park presented the specimens from a case of *resection of the cancerous pylorus.* The patient was a young married woman, who had borne four children. She had been in good health until five years ago; since then had suffered from some indefinite gastric trouble. Family history was good. Since last fall she had noticed a tumor in the epigastrium, which had grown steadily, though it was still very movable. During the three weeks prior to examination she had vomited everything ingested, and was excessively reduced. There was no difficulty in recognizing a cancer of the pylorus.

After a few days preliminary treatment she was operated upon February, 19, 1889. Complete exsection of the cancerous pylorus was made, a considerable portion of the greater curvature of the stomach being also removed—altogether about one-quarter of its entire extent. The operation transpired to the operator's satisfaction, lasting one hour and forty minutes. The patient progressed remarkably well for two days, and then signs of exhaustion appeared and she died in collapse, 63 hours after the operation.

Upon autopsy the stomach was found to contain over a pint of altered blood. The hæmorrhage had evidently come from a minute vessel in the mucous membrane at the upper extremity of the incision. Every stitch held perfectly; there had not been a drop of leakage, nor was there the slightest sign of peritonitis. Apparently had it not been for the loss of blood the patient would have recovered. The specimen showed a beautiful type of a large pyloric cancer, there being such a degree of stnerosis that a match was with difficulty passed through the opening.

Dr. Park also exhibited the specimens from a recent case of *partial extirpation of the larynx.* A man, about 45 years of age, suffered from a rapidly growing malignant tnmor in the larynx, which involved one arytenoid cartilage and its adnexa, but had not crossed the middle line. He was rapidly failing when he accepted the chance of an operation, which was made February 23rd. Extirpation of a lateral half of the thyroid cartilage, together with the arytenoid and the epiglottis, was practiced. Everything went off satisfactorily so far as the operation was concerned. But on the following day symptoms of pneumogastric irritation supervened, viz.: sudden cardiac turbulence, intense dyspnœa which was in no wise obstructive, and angina-like attacks. As these recurred he grew weaker and weaker, and died in one of them about twenty-eight hours after operation.

Beyond the presence of the neoplasm the specimens showed nothing save the appearance of the parts, after such an operation, which illustrates the smoothness and exactness with which it can be done.

Balloting resulted in the election of both candidates.

Dr. F. H. Potter showed two instruments invented by himself. One was a new nasal speculum, the other a saw apparatus for removing hardened tissue from the nasal passages. He intends to bring out a fuller report with plates at a later period.

Book Reviews.

EXPLORATION OF THE CHEST IN HEALTH AND DISEASE. By Stephen Smith Burt, M. D., Professor of Clinical Medicine and Physical Diagnosis in the New York Post-Graduate Medical School and Hospital, etc. New York: D. Appleton & Co., 1889.

This little book is the outcome of urgent requests from a class of listeners who desired elementary instruction in enduring form. The introductory explanation delays the penalty which a writer on hard worn themes unavoidably incurs and attention is quickly attracted by the clear simple English and easy conversational style which mark the text.

In the effort to be explicit and concise the attempt at literary excellence has been sacrificed at times, but the manner in which old accustomed facts are reintroduced and associated lend them a renewed charm, to invite acquaintance and render future recognition less difficult for the novice. We find nothing new and while wondering why recent contributions have not been included, question the wisdom of the query in a dual thought. Only the principle and reliable signs are mentioned or discussed and no attempt is made to draw fine distinctions which too often perplex and mystify the student of trifling experience. Every sentence is plainly addressed to the beginner and the statement is positive as it should be. There is enough material to guide safely and it is arranged most clearly with regard to the character of information and the facility for comprehension. The moderate cost and convenient size of the handbook will prove advantageous. As a competitor for popularity among many others more exhaustive, its success will depend largely upon the fact that the cause and meaning of the rough music of noisy function is told in pleasing narrative, novel and interesting. The work deserves praise and cordial recomendation. J. H. P.

From Wm. Wood & Co., N. Y., through J. H. Matteson:
Reference Handbook, Vol. VII.
Handbook of Therapeutics: S. A. Ringer.

From Open Court Pub. Co., Chicago:
Psychic Life of Micro-Organisms: A. Binet.

From F. A. Davis, Philadelphia:
Materia Medica: Cuthbert Bowen.

Transactions of the Association of American Physicians, Vol. III.

MEDICAL NEWS NOTES.

The Kensington Hospital for Women, Philadelphia, established in 1884, and chartered in June, 1887, is the oldest incorporated hospital in the state of Pennsylvania for the treatment of diseases of women exclusively. It is especially designed to do charity work, and no suitable case has ever been refused. An enormous amount of abdominal surgery and plastic work on perineum, vagina, rectum, cervix, urethra and bladder is done there yearly, with the best results. The managers of the hospital intend transferring it to West Philadelphia, in the immediate neighborhood of the University grounds, where much of its valuable work will be available for instruction. A fund of $40,000 is being raised for this purpose.

Dr. J. M. Nilsen, of New York, having performed a very severe and difficult abdominal operation on a woman, has to confess that she "became demoralised by the unwonted care she had received in hospital, and by the help extended to her after she left, for, although she improved steadily in appearance, she refused even to try to work up to the time of her last visit, about eighteen months after the operation." She evidently appreciated to the full the credit she brought to the operator, and thought that the science of gynæcology owed her a perpetual pension.

According to a hospital physician there is no bed so good for the patient in cases of long illness as the hammock. He recommends the hammock not only because of its undeniable sanitary excellence but because of all places of rest, all couches or beds, he believes it to conform best to the various curves and outlines of the human form. For bedridden people this doctor considers it invaluable.

STATE asylums for the insane generally take better care of them than the county institutions, for the obvious reason that specially competent supervision is more easily obtained for a single large institution than for a number of small ones. New York state is agitated from one end to the other regarding this question.

Publisher's Department.

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ELECTRIC CATAPHORESIS AS A THERAPEUTIC MEASURE.

By Frederick Peterson, M. D., New York.

[Abstract of a paper presented at the annual meeting of the Alumni Association, Medical Department University of Buffalo.]

If two compartments separated by a membrane be filled with a fluid and in each an electrode be placed, there is a streaming of the fluid through the membrane in the direction of the galvanic current, that is, from the positive to the negative pole ; so that in the course of time there is an increase of the fluid in the compartment containing the negative pole. This movement is so marked that it overcomes the natural osmotic current which is always from the lighter to the denser liquid. Du Bois Reymond had called this phenomenon the cataphoric action of the constant current. Dr. Peterson had attempted to utilize this action of electricity for the purpose of introducing medicines through the skin. He had first made a large number of experiments upon himself with cocain, chloroform, aconitia, and helleborin. In order to be positively sure of his results he had applied these drugs in strong solutions to the skin, first without electricity, then with the negative pole or cathode, and finally with the positive pole or anode. Over thirty of these experiments he had recorded in minute detail, as to the number of minutes application, the quantity of electromotive force, the number of milliamperes current strength and the strength of drugs used.

He found that the cataphoric action of the current was absolutely as marked through the skin as it was through any membrane, and that solutions of the drugs mentioned, when placed upon a sponge-covered anode and applied to the skin, were driven into the tissues and produced anaesthesia in a very few minutes to touch, temperature and pain. The solutions of cocain used were 10 to 20 per cent; of helleborin 1 per cent; of aconitia 4 grains to the ounce; and Squibbs pure chloroform.

The solution he would recommend for use as a local anaesthetic were either a 10 per cent. or 20 per cent. solution of cocain, or a mixture of cocain and aconitia (equal parts of cocain 20 per cent solution and aconitia, 4 grains to the ounce).

He had then employed cataphoresis with success in various neuralgias of the superficial nerves, such as a supraorbital neuralgia of 1½ years duration; a supraorbital neuralgia of 12 years duration; an inferior maxillary neuralgia of 3 weeks standing; the dorsal pains of locomotor ataxia; a case of double trigeminal neuralgia of one years duration, and a number of other cases, all selected as having suffered for a long time, and as having proven intractable to any other remedy. The following were some of his conclusions: That there is a cataphoric action of the constant current when applied to the skin is beyond doubt or question. A deep anaesthesia may be produced by the use of cocain, or cocain and aconitia combined, upon the anode, sufficient for the relief of pain, even of severest superficial neuralgias, for from 4 to 11 hours; and sufficient for small operations such as the removal of cutaneous growths or the electrolysis of hair roots.

Wherever the anode is used for the relief of pain its efficacy will be greatly increased by moistening it with a 10 to 20 per cent. solution of cocain. It is of particular benefit in neuralgias of the trigeminus and its branches. He would not claim a curative effect, but absolute relief from pain for from 4 to 11 hours, without constitutional effects, from the remedy used in this way.

He had devised two electrodes for the purpose, a simple cataphoric electrode which is quite sufficient for all clinical purposes and a more perfect cataphoric electrode useful for determining dosage and for more accurate physiological experiments. These were manufactured by Waite & Bartlett, electricians, New York.

He suggested the use of electric cataphoresis, also, with iodine upon the anode, in cases where iodine was to be employed as a local application over swellings or tumors.

Eight to fifteen cells may be used for from 5 to 20 minutes. This is an average application, but there is a difference in the resistance of patients and in the strength of batteries; so the best index is to be gained by the feelings of the patient. A barely perceptible current is efficacious but requires a long time. A current that causes prickling at the anode will produce the desired result in about 10 minutes. If a galvometer is at hand the current strength should be read off at from 5 to 10 or more milliamperes. The whole paper will appear in the *New York Medical Journal* soon.

CARDIAC DILATATION AND ITS TREATMENT.

BY H. R. HOPKINS, M. D., BUFFALO, N. Y.

[Read before the Annual Meeting of the Alumni Association of the Univ. of Buffalo, March 26, 1889.]

Mr President, and ladies and gentlemen of the Alumni Association; your speaker has selected the subject of "Cardiac Dilatation" for two reasons: First, because opportunity has been given him recently to make repeated observations upon this form of cardiac disease; and, second, because of the conviction that there is a necessity for the adjustment of emphasis in regard to the teaching of our text books upon this subject. Certainly those books most frequently consulted at the time when your speaker received his education, laid much stress upon the importance of the detection of abnormalities in the valves of the heart, while very little was said regarding the abnormalities of the walls of this organ. I believe it is not far wide of the mark to say that in the examination which most of the members of our profession are accustomed to make to-day, the attention is chiefly directed towards the detection of the abnormal conditions or sounds having their origin in the valves of the heart; and when an examination has reached a point where the mind of the examiner is clear as to the existence of an aortic regurgitation or a mitral insufficiency, he considers that his whole duty has been done, and the subsequent treatment and history of the case take shape from his observations as to the conditions of these valves, practically leaving out of question the condition of the walls upon which these valves are attached. More recently eminent and practical men of our profession have directed attention to the importance of the observation of the condition of the heart walls, maintaining that a rational prognosis and a rational treatment depend largely upon the correctness of view as to the conditions of these walls. Authorities are accustomed to refer to dilatation of the heart as a condition in which the cavities of the heart are abnormally increased in size. This condition presents certain varieties which either exist alone or in combination.

VARIETIES.

The first variety to which I would call your attention is that denominated simply "Cardiac Dilatation." In this condition the cavities of the heart are dilated, the thickness of the walls remaining the same.

The next variety of cardiac dilatation is known as the hypertrophic variety. In this state not only are the cavities of the heart enlarged, but the walls are correspondingly thickened. The third variety of cardiac dilatation is known as the atrophic, and practically this variety is the only one of significance. In atrophic cardiac dilatation the cavities of the heart are enlarged, and the walls are correspondingly thinned and enfeebled.

CAUSATION.

The forces which are at work in the system to produce cardiac dilatation are those which affect the integrity of the heart muscle, and those which augment the work which the heart has to do. Of the former the various inflammatory conditions affecting either the heart or its investing membranes are of chief importance; and we will bear in mind, therefore, the necessity where the history of the case reveals that the individual has at some time previous suffered from parietal endocarditis, that, as a result of this disease, fatty or fibroid degeneration of the heart walls is liable to occur. Certain other general states of the system also tend, not infrequently, to the production of cardiac dilatation. In the conditions of profound anæmia, or of grave sclerosis, the nourishment of the heart muscle is so deficient that it is unable to do its accustomed work, and following the order of ill-nourished and tired muscles generally, it becomes parietal, and cardiac dilatation ensues. In this connection it is also important to state that the operation of certain specific poisons, such as that of diphtheria and of typhoid fever, also result in producing temporary cardiac dilatation. The abuse of certain alkaloids, particularly those of tobacco and tea, have, under my own observation, operated to produce this condition in the highest degree. I can recall at this moment the case of a lad who fainted three or four times in his office — whose cardiac action was of the greatest feebleness and inefficiency—also confessed to me that his habitual consumption of cigars for some weeks had reached as high as 20 or 30 per day. The most careful hygienic and medical treatment, lasting over two years, did not entirely eradicate the cardiac enfeeblement resulting, in my judgment, entirely from the misuse of the tobacco. In servant girls I have frequently met instances in which the abuse of tea acts in a similar manner. In attempting to mention the elements which cause cardiac dilatation it would be improper to overlook such local states as insufficient or obstructive condition, of either the mitral or aortic valves. Inefficiencies of this sort must necessarily act to increase the work done by the heart walls, the ultimate result of which must necessarily be heart tire and heart dilatation. Of the causes acting in the system at large which tend to increase the work of the heart that which is most frequently met with is renal sclerosis. The high arterial tension which exists in all such cases points unmistakably to the increased cardiac effort. This increased work necessarily leads to compensating hypertrophy, which hypertrophy in time gives way to dilatation. I have also frequently observed cases in which persistent asthma had resulted in dilatation of the right heart, very serious in degree.

One other systemic condition, in my judgment, requires notice before closing this part of my remarks. The condition now so frequently referred to as lithemia is frequently the cause of functional, high arterial tension. This high arterial tension existing in the presence of slight cardiac feebleness is known in many cases to produce cardiac dilatation. Before proceeding to speak of other matters it is well to remark that the auricles are much more frequently the seat of this peculiar condition, and that of the ventricles, the right suffers much more frequently than the left.

SIGNS.

The local signs of cardiac dilatation are exceedingly straightforward and uniform. That to which I would first call your attention we will denominate a labored action of the heart. Associated with this peculiar heart action is invariably found a feeble pulse. Judging from the tumult of the heart, a bounding heart-pulse might be expected. Observation instantly reveals that this is not the condition. The pulse of cardiac dilatation is uniformly small, feeble, and when the condition is advanced in any particular degree, is irregular. If the right auricle is the seat of the diseased state, fullness of the veins of the neck would habitually be noted, and when both auricle and ventricle are affected, pulsation of the veins will always be present. To return once more to a consideration of the action of the heart. Upon inspection of the chest, an increased area is found to be quite extensive, not infrequently to extend from an inch to the left of the nipple line to the centre or even to the right of the ensiform cartilage. By observation, the impulse delivered over this large space will soon be detected to be, not a single impulse but a prolonged, undulating, wave-like impulse. This is as different from the heaving throb of cardiac hypertrophy as it can possibly be. The history of the palpitation of cardiac dilatation is very uniform. Patients narrate that when they first observed the palpitation, it came only as the result of some special trying effort, from climbing a particularly long flight of stairs, from walking up a step ascent, or from walking rapidly against a stiff wind. That this was the case for some months, but that gradually the condition increased until now palpitation is brought on by the slightest effort. When cardiac inefficiency reaches this degree, dyspnœa becomes as habitual as palpitation, and the combination of these two symptoms, habitual palpitation with disturbing dyspnœa, renders existence anything but tolerable. Examination of the patient reveals habitually an extremely and anxious countenance, with livid lips, with a bearing which impresses you that every possible motion is regulated with the most rigid regard to the necessities of the inefficient heart and lungs. With the anxious countenance and livid face are also associated cold hands and feet, which are slightly œdematous. A history is frequently given also of slight syncopal attacks, in which consciousness is either greatly obscured or altogether lost for a few moments. In a great majority of cases cerebral anæmia with its wide range of symptoms attends every case of cardiac dilatation. As the weakened heart becomes still more feeble the slight œdema of the feet increases, dropsy into the pleural cavities take place, insomnia from cerebral anæmia becomes the habitual state, and death closes the unhappy scene from pulmonary œdema or renal failure. To return for a moment to the physical signs. The large lateral dullness extending from the left nipple to the right of the ensiform cartilage will show ventricular dilatation. Dilatation of the auricles will be revealed by an increase of the normal dullness in the upper direction, also by the venous fullness or venous pulse. Auscultation under such circumstances will frequently reveal a marked similarity in the first and second heart sounds. Systolic murmurs are habitually detected and that condition known as asystolism, in connection with which the murmur is so indistinct as to be placed with difficulty either with the first or second sound. Cardiac dilatation is to be differentiated from cardiac hypertrophy and from pericardial effusion. From cardiac hypertrophy the diagnosis is easily made. It would be impossible to confuse the full, hard and bounding pulse of cardiac hypertrophy for the weak, feeble, small, irregular, intermittent pulse of cardiac dilatation, or to mistake the vigorous, full-blooded, active man with the enlarged heart for the feeble, anxious, short-breathed sufferer from cardiac dilatation. In the local manifestation the symptom in common is an increased area of cardiac dullness. In hypertrophy the impulse is tumultuous, wavy, prolonged. Between pericardial effusion and cardiac dilatation the diagnosis is not easily made. In each there is the common quality of the increased area of dullness. With the effusion the impulse is more suppressed, more feeble than in dilatation, and with the effusion there is generally the history of fever and acute illness attending the pericarditis.

PROGNOSIS.

The prognosis of cardiac dilatation is always serious. In many cases in which the dilatation follows upon organic disease of the valves, or is complicated by organic disease of the kidneys, or is the result of serious fatty or fibroid degeneration, the prognosis is necessarily hopeless. In many cases, particularly those resulting from the acute fevers, typhoid or diphtheria, those caused by the abuse of tobacco and tea, and those produced by the operation of an inordinate strain such as mountain climbing or forced marches, a hopeful prognosis may be entertained.

TREATMENT.

Regarding the treatment of this condition, I have first to emphasize one principle, and that is the principle of rest. It is only since the introduction of Dr. Weir Mitchell's "Rest Treatment" that the medical profession seem to have thoroughly realized what rest means. Ordinarily the conception is that a man must stop his work, take a vacation, or that the woman must secure the services of a servant, and direct her affairs instead of performing them herself; but since Dr. Mitchell's remarkable addition to our remedial measures, we have come to more minute and particular views of the matter of rest. When a patient suffering from cardiac dilatation is put to bed, when the blood habitually circulates for weeks and months upon a horizontal plane; when every voluntary effort that can be relieved is relieved, when the patient is not permitted to turn over in bed, not obliged to adjust his own bed-clothes, to feed himself, to brush his hair, to brush his teeth, nor to do any single act which an attentive and discriminating nurse can do for him, we begin to approach the idea of the application of rest to the treatment of cardiac dilatation; and when in addition to all this we institute massage, exercise without exerting the venous heart, we are still only assisting the circulation, only keeping active and healthful the lymph streams, we are only aiding to maintain the standard of general nutrition while our patient gets the benefit of the application of the great principle of rest. A rational treatment would of course be shaped somewhat by a consideration of the causation at work in the individual case, and the exclusion of all pernicious agents or practices, such as the the abuse of tobacco or tea, or the use of such articles of diet as may have contributed to the production of lithemia. Such vicious practices as sexual intemperance should receive consideration. It is also well to remember that the action of the skin, whereby the labor of the heart is greatly lightened, is improved by the wearing of flannels. In cases that have reached the stage that we may consider as convalescent, the condition will be greatly improved by a change of residence to one of sufficient elevation to insure a dry and bracing air.

In speaking of remedies of a general character I must not omit to refer to the beneficial influences which may be derived from a systematic course of Turkish baths. The rest which is given the heart by the greatly improved condition of the skin which this process insures, is, I am sure, of the greatest practical importance. Furthermore, the purifying influence of the blood which the bath promotes, shows itself by the increased power manifested by the failing heart when that heart is supplied with blood freed from all impurities.

My personal observation upon cases who have availed themselves of this means now extends to many cases during many years, and I can speak of the matter with great confidence and assurance. The question of the selection of a climate for cases suffering from this trouble is one of great importance. Under ordinary circumstances it would seem in every respect fool-hardy to recommend such to seek a high altitude, but my own experience is in accord with the testimony of the most recent writers who advise their patients to seek the higher altitudes from 2000 to 3000 feet above sea level. My own impression is that the superior oxidation of the blood, whereby the heart gets nourishment of a superior kind, is an important factor in the improvement which comes to such cases. Of the use of drugs I can speak most confidently of the uniform benefit to be derived from digitalis. In cardiac dilatation one of the symptoms which marks the inefficiency of the heart is the failure of renal secretion. By observing its secretion, it will usually be ascertained that the total quantity in 24 hours does not exceed one pint, and may often fall as low as half a pint. Under the exhibition of digitalis given in doses from 25 to 50 drops, twice a day, a marked change in this respect will be observed. After from three to four days of such treatment the quantity of urine will be doubled, or even trebled, and so long as the kidneys continue to do this increased work, so long may we be sure digitalis is a remedy of great good. In this connection a word of caution is necessary. If during the course of an exhibition of digitalis the quantity of urine fails, and falls to something like a pint or less in 24 hours, the digitalis should be immediately withdrawn. Under such circumstances the exhibition of a few doses of calomel alone or combined with elaterium will frequently restore the balance of circulation, and permit the digitalis course to be resumed with advantage. Recent years have brought to the notice of the profession several cardiac stimulants and tonics whose action are in the main similar, yet possess individual qualities. convallaria, strophanthus and sparteim are now at our disposal. In regard to convallaria and strophanthus, I would say that their action is so similar to that of digitalis that in cases where the former does not seem to agree with the patient, does not seem to produce the result which you legitimately expected from it, one or the other should certainly be tried. Of spartein it can be said that it possesses this advantage over digitalis. With digitalis the action is very slow. Frequently two, three or four days elapse before its full power is manifested. The action of spartein is almost instantly manifested. In severe and critical cases advantage can be taken of this, the rapidly acting spartein doing the work which the slower digitalis will continue. But two more remedies require to be spoken of. Where the staggering heart is well nigh at the point of failure in its work, amyl-nitrite and glonoin can confidently be appealed to for immediate relief. In severe cardiac dilitation and consequent dyspnœa, which so frequently attends the closing days of renal sclerosis, there is no remedy which equals in immediate efficiency the hypodermic of morphia. Many authors will caution and protest against the use of so potent a remedy in a condition in which uræmic coma is to be momentarily expected, but I have the liveliest recollection of instant and complete relief following such exhibition in many cases in which life seemed to be practically despaired of.

A CASE OF LAPAROTOMY AND ABDOMINAL DRAINAGE FOR PUERPERAL PERITONITIS.

BY Z. H. EVANS, M. D., BAY CITY, MICH.

I was called January 25th, 1889, to see Mrs. Benson, German, aged 34, mother of four children. Upon my arrival at the house I learned from the husband that one week previous to my visit she had miscarried at three months. At that time flooding took place to the extent of saturating the mattress through and through with blood, all of which was allowed to remain on the bed up to the time of my visit. Owing to the stifling stench it was impossible at this time to make any examination. I therefore ordered the patient to be sponged off with warm water and the vagina irrigated with a weak solution of carbolic acid—promising to call again later in the day. At my next visit I found the sanitary condition of the patient somewhat improved, although the stench was lingering still. I now proceeded to the examination of the patient by first taking the temperature, which was found to be subnormal, pulse 157, respirations 34. Tongue presented a dry, dark fur down its center, while the abdomen was distended to a marked degree, and the entire body bathed in a cold clammy perspiration. In fact I considered the patient to be in articulo-mortis. The case being of such a nature I was desirous of the council of my friends Dr. E. G. Miner and Dr. E. A. Elliot and requested that they be sent for at once; on their arrival they gave the patient a thorough examination and stated as their opinion that she had but a few hours to live, (which opinion was thoroughly in accordance with my own). After communicating to the husband the views of the physicians, he inquired if there were nothing further to be done. I replied, by saying, that the only chance to save the life of his wife "was to open the abdomen and wash it out." He at once acknowledged his willingness to permit the operation and requested that it should be done at once. After a brief consultation with the physicians present, we decided first to try and stimulate the patient. I therefore ordered whisky, milk, carbonate of ammonia and tr. digitalis to be injected every three hours during the night into the rectum. On calling the next morning much to my surprise I found the patient still alive and she expressed herself as feeling a little stronger, although there was nothing to be observed to warrant any such statement. The fact that she was entirely free from pain led the husband and friends to believe that the patient was better, but the very fact that she was free from pain convinced me that it was but one of the early preludes to approaching death, and so expressed myself to the husband and friends and at once made ready for the operation. Dr. Miner gave chloroform to the patient while still in bed and when she was slightly under its influence she was placed on a table opposite a good light and the abdomen opened as speedily as possible. She was then turned upon her face and a quart of serum allowed to drain away. At the same time I placed my hand over the wound in the abdomen in such a manner as to prevent the intestines from protruding. When the serum had all drained out the patient was turned back on the table and, with the aid of a Davidson syringe, the cavity of the abdomen was flooded with plain warm water, and again the patient turned upon her face as before, and the water allowed to run out. The second time the water was clear and free from any tinge or color. A large size soft rubber drainage tube was now inserted and carried to the lower portion of the abdomen. Four deep sutures were passed, a compress of cotton and a flannel binder applied ; this constituted the entire dressing. The patient was now placed in bed, more dead than alive, was surrounded with dry heat, and after a few hours recovered from the shock of the operation. On calling early the next morning I was delighted to learn that my patient had during the night drank nearly one quart of milk and retained it, something that she had not been able to do for some days. Found the temperature 101½, pulse 112, respirations 20 and the skin moist. She remained in about this condition until the evening of the third day, when she had a violent chill which lasted for nearly one hour. I was at once sent for and on arrival found a pulse of 158, temperature 105½, respirations 33, delirous and picking the bedding with her fingers. I at once removed the drainage tube and upon examination found the lower end plugged up with thick pus. This fact at once convinced me that there was more pus in the abdomen and I therefore reopened the wound at once and flooded the cavity with warm water, afterwards closing the wound with adhesive plaster. There came away at least a pint of pus. The intestines were matted together and had to be separated with the finger. I again ordered the injections of whisky and milk be given every three hours during the night. Calling again early the next morning found her asleep, and learned from the husband that she had slept well the latter part of the night, pulse 105, temperature 101, respirations 20, skin moist and the entire body warm. From this time on she gradually improved and at the expiration of five weeks from the date of the operation she had so far recovered as to assume the duties and cares of her household.

IT IS well known that some patients become so much attached to the hospital wards that they would glaply spend their life—a good long life, too—there. For chronic cases of this kind there is kept at the New York Hospital a medicine, bearing in prescriptions the name of *Mistura Errabundi*, but known in the vernacular as "The Undertaker's Revenge." It consists of an appetizing mixture of copaiba, castor-oil, and quinine, and has been found most efficacious.

A CASE OF CÆSARIAN SECTION.

FROM THE CLINIC OF PROF. WM. GOODELL.
University of Pennsylvania.

Reported by DeWitt H. Sherman.

Though this is an operation which dates back to the early part of the seventeenth century, it is not yet followed by the favorable results that might be expected, considering the tremendous advance of surgery. The mortality has been very large especially in those cases operated upon in hospitals, where the general health of the women was not as good as that of those in better circumstances of life. But the larger percentage of the mortality has probably been due to the exhaustion of the patient from a long labor, caesarian section having been performed too late, being resorted to as the last method for relief.

The history of this case is as follows: Mary B., 32 years old, was married at the age of fourteen. Has had eight children and four miscarriages, the last being twins. In February 1888, she complained of bleeding from the vagina. An examination showed a tumor at the cervix, which upon curetting was found to be carcinoma. It was about the size of a hen's egg and has continued to grow, till at the present time its dense mass almost completely obstructs the vaginal canal. It involves the septum between the vagina and rectum, and that between the vagina and bladder, but has not ulcerated into either.

The indications for caesarian section were:

1st. Had labor been allowed to come on normally, such severe laceration would have been produced that death must necessarily have followed from hemorrhage.

2nd. Mechanical dilatation of cervix would have caused death in the same way.

3d. The child could not have been delivered alive through such a narrow channel.

4th. The woman was in good physical condition and courageous to undergo the operation.

The morning of the operation the patient's bowels were opened and the vagina was thoroughly douched with corrosive sublimate solution (1–4000.)

After preparing the parts with most careful antiseptic precautions, an incision was made in the median line from about one-half inch above the navel to a short distance above the symphysis pubis, all hemorrhage being checked by haemostatic forceps. Upon reaching the peritoneal cavity Dr. Goodell chose to open the uterus in situ, rather than by the other method of drawing the womb forward outside of the cavity. An assistant exerted firm pressure on either side of the womb to prevent as much as possible free circulation in the part, and to retain in place the intestines, and the sponges which had been placed in the abdominal cavity to absorb the liquor amnii after rupture of the membranes. An incision was made down the middle of the uterus and the child, having normally a breech presentation, was delivered as quickly as possible, and the cord ligated and cut. Immediately a rubber tube was tied around the cervix and the hemorrhage was arrested.

The child was given into the charge of Dr. Hirst, and soon from an adjoining room gave evidence of being alive and lusty.

The placenta which was attached to the left and posterior walls of the uterus was easily freed from its adhesions and removed.

The uterus was then thoroughly cleansed with corrosive sublimate solution and the closure of the wounds begun by Sanger's method. Interrupted silk sutures, fourteen in all, were inserted one-half inch from the edge of the wound on its external surface and brought out through the sub mucosa on the inside of the wound, without perforating the mucous membrane. The mucous membrane was avoided as far as possible, because by piercing it, direct communication would be made between the cavity of the uterus and the peritoneal cavity, and in this way septic discharges from the uterus or vagina might pass and cause septicaemia. The edges of the serous membrane were then drawn down into the wound and stitched together by seventeen Lembert's sutures. Upon these two sets of sutures, superficial and deep, and upon antisepsis, seems to depend the success of this method of operating.

After the wound of the uterus had been firmly closed, the rubber binder was taken from the cervix and blood allowed to circulate through the womb, and as the parts had been accurately approximated no hemorrhage followed. Upon the removal of the sponges from the abdominal cavity, it was thoroughly cleansed with water which had been previously boiled. So slight were the discharges which had collected there that the wash water came out almost clear.

In approximating the abdominal wound the sutures were passed through the tendon of the rectus muscle and as much internal tissue as possible, to firmly bring the sides of the wound together in order to prevent ventral hernia, which, in spite of the greatest care, sometimes occurs. As the incision was extended around and above, the umbilicus was excised before the parts were brought together and the whole wound was sewed up, no drainage tube being used. Iodoform was freely applied, with coverings of iodoform gauze, cotton and binders, the conventional antiseptic dressing.

The last step of the operation was the insertion of the index finger into and through the os to open up a clear passage way for drainage. Chloroform was used in preference to ether to avoid the nausea and retching so common to the latter and the suppression of the urine which is apt to follow the irritation of the kidneys caused by the elimination of the ether.

For twenty-four hours after the operation the woman was given nothing to eat or drink. She suffered a great deal from thirst and after pains and from the latter was relieved by opiates. At the end of the twenty-four hours she was given a half cup of tea and afterwards her diet was a half cup of milk every two hours.

The babe was put to the mother's breast very soon after the operation and took its nourishment nicely.

Clinical Lecture.

VARICOSE ANEURISM OF ARCH OF AORTA.

By Prof. Wm. Pepper, M. D. LL. D.

Analysis of case at the Hospital of the University of Pennsylvania.

[Stenographic report by A. L. Benedict, M. D.]

Chinaman. No reliable previous history. History of exposure, sleeping in a cold damp cellar after working hard in a laundry overhead. Sharp pains in the chest, oppression, some cough, and quickly following this œdmatous swelling of the face, neck, arms and trunk down to the base of the chest. With this swelling lividity. Careful examination excluded renal disease. No œdema of legs at all. No organic disease of lungs. Everything pointed to an obstruction of the venous circulation affecting the distribution of the superior vena cava alone. Over the chest on both sides were clusters of greatly dilated tortuous veins. Examination of the heart did not show any extensive organic changes.

There was evidence, then, either of pressure upon the vena cava superior or of obstruction by a clot. The man complained somewhat of difficulty in swallowing, but he was always able to swallow. His breathing was short. Anorexia. Voice weak and husky, but this appeared to be due to weakness and dyspnœa, rather than to pressure upon the recurrent laryngeal. Laryngoscopic examinations were always unsatisfactory on account of the distress to the patient, though apparently there was no paralysis of the vocal cords. There was no external tumor nor were there any enlargements of the lymphatic glands. Age, absence of history of syphilis, absence of history of straining, lack of dullness on percussion, lack of hearing any abnormal pulsation at any point outside of the heart's area, equality of the radial pulses, were against aneurism.

In the second intercostal space and in the first space also, there was a constant venous hum which rose and fell in force corresponding to the pulsations of the heart. This was a musical murmur, differing from a cardiac murmur and from an aneurismal bruit. It was concluded therefore, that there was an obstruction of the vena cava, the history being against pressure from without either by solid tumor or aneurism. For two days before death, the murmur in the chest disappeared entirely.

REPORT OF AUTOPSY:

No œdema below the waist. Profuse venous oozing on cutting through the skin of the thorax. All the tissues in the anterior mediastinum were highly œdematous and matted together. The pericardium contained one ounce of somewhat bloody serum. Upper part of pericardium somewhat roughened and granular. Heart of medium size. Tricuspid and mitral valves normal. Right auricle enlarged and its walls somewhat thickened. Inferior vena cava admits two fingers up to the first joint. Superior cava admits an index finger to the second joint and there the finger becomes tightly compressed. Aortic valves normal, aorta a little dilated. One and a half inches from aortic valves is an opening on the posterior aspect of the convexity of the arch, one inch in diameter. This opening leads into an aneurismal sac projecting backward and to the right and of the size of a small orange.

The tissues around the sac are thickened. It is bounded on the right by the right lung which it compresses, posteriorly it lies on the right bronchus and adjacent structures. At the junction of the right internal jugular and subclavian veins, behind one of the valves is a globular thrombus. The sac is filled with blood-clots which are not laminated. The aneurism had begun to cause absorption of the cartilages of the trachea. The superior cava much thickened and compressed by the aneurismal sac. At this point the superior vena cava does not admit the tip of the little finger, but a probe passed in enters directly into the aneurismal sac.

The aneurism laid open shows an irregular erosion into the inner wall of the superior vena cava, three-fourths of an inch in length. The edges of this opening are not occupied by any clot. From the right auricle a probe also enters the aneurismal sac. The wall of the vena cava superior formed part of the posterior boundary of the aneurism for at least one inch. The openings from the aneurism into the aorta and the vena cava are both elliptical. The oesophagus is tightly adherent to the aneurism and seems to be compressed.

THE practice has existed in the State of New York since 1864 of confining insane persons charged with crime at the Auburn State Asylum for Insane Criminals has seemed to many to be in need of revision. Senator Pierce has introduced into the Legislature a bill to discontinue the practice. In addition to this measure, others affecting the lunacy laws are before the Legislature for its consideration. One of these provides for the appointment of six commissioners to revise all the laws of the State relating to lunacy; another, if passed, will substitute a commission for the one existing commissioner; still another measure provides for the care of the dependent insane in State rather than, as is now the practice, in county institutions. This latter bill seems to us to be by far the most important of all those which have been introduced during the present year. The proposed plan would put a stop to the abuses which are believed to exist in some of the present institutions, and is, for this and many other reasons, supported by the medical profession and layman who are familiar with the disadvantages of the present system.

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BUFFALO, N. Y., MAY, 1889.

ABDOMINAL SECTION FOR PUERPERAL PERITONITIS.

"The existence of purulent peritonitis however induced is a clear indication for abdominal section," says Greig Smith; a view which while generally admitted to be true has rarely, at least on this side of the Atlantic, been acted upon.

As far as concerns puerperal peritonitis, the case reported in this issue by Dr. Evans is one of the first, if not the first, which has been successfully operated upon in this country. We call the special attention of our readers to this case both on account of the boldness of the operator and of his success, and because it opens up a future in the treatment of these desperate cases.

There is really no reason why pus within the abdomen should not be let out as well as pus within the pleural sac or within any other serous cavity. Under such circumstances the cavity becomes simply a huge abscess and as such should be drained. Nor does it make any difference what the origin of this pus may be. It is all the same whether it comes from the bursting of an abscess of the ovary or from a gonorrhœal salpingitis, or from a suppurative process originating within the uterus after confinement and extending through the tubes to the peritoneal cavity. The pus if present must be evacuated before recovery can take place.

Several things stand in the way of the general adoption of this operation. One is the traditional fear of the peritoneum—a fear which still lingers in the minds of the general profession, but which has long since been banished from the thoughts of the laparotomist. If there is already inflammation with pus formation, what worse can happen, what harm can the opening of the cavity do? Such an incision if made with proper care is in itself absolutely without danger, as has been proved over and over again. So if no good is done, as might happen in the case of a mistaken diagnosis, no harm will result.

The desperate condition of the patient in this disease may be urged as an objection; but desperate diseases sometimes demand desperate measures. The shock of an anæsthetic is rightly to be dreaded; but this can be avoided as has been repeatedly shown by the use of cocaine, hypodermically. In this way the incision may be made perfectly painless.

Smith recommends after opening the abdomen, if the patient is in a very low condition, to be content with simply at first introducing a drainage tube to the bottom of the pelvis, and then waiting until some improvement takes place before attempting to break up adhesions and thoroughly wash out the whole cavity.

A glass drainage tube is much to be preferred to the rubber tube used by Dr. Evans. On account of the tympanitis usually present a long tube may be necessary.

We sincerely trust that those of our readers who are so unfortunate as to meet with cases of this disease, whether puerperal or not, will give this operative treatment fair consideration and a trial; for we are convinced that by it many valuable lives otherwise certainly doomed can be saved.

THE INSANE IN FOREIGN COUNTRIES.

There has lately appeared from the press of G. P. Putnam's Sons, of New York, an elaborate and beautiful work by a gentleman so well known in Buffalo that he may almost be called a fellow townsman. We refer to the Hon. Wm. P. Letchworth's work entitled, "The Insane in Foreign Countries." It is a magnificent octavo volume of 374 pages, dedicated to the Governor of this State, and is the outcome of a most extensive foreign trip during which a large number of charitable institutions were visited, carefully examined, and contrasted with each other and with our home institutions as well. The information thus collected has been sifted with great care and is now put before the public in exceedingly attractive form; though the typographical beauty of the work, which we understand has been put forth virtually as a private undertaking, is scarcely to be compared with the great value of the observations made by Mr. Letchworth, which has led to its publication. Not only were the visits to these institutions made with due expenditure of time and skill in observation, but usually a stenographer accompanied the visitor, in order that the valuable opinions expressed by the distinguished specialists in charge of these hospitals and asylums might be carefully recorded. The whole aim of the work has been to demonstrate, from a practical point of view, the most advanced, humane and economical methods of caring for the demented.

To the reader not especially interested in the care of the insane, the most interesting chapters are perhaps the first and the last. The first chapter is both introductory and retrospective, and is a most interesting summary of the methods of dealing with the insane in the past, from the time when they were regarded as possessed by demons and were cruelly punished and tortured, or even put to death. It is not strange that at a time when demonology and witchcraft were fully believed in, the method of dealing with these unfortunates was unspeakably cruel and inhuman. Towards the close of the sixteenth century certain medical authorities began to openly rebel against these practices and were thereupon severely censured by King James VI. of Scotland, he, who by the way, wrote a book on demonology, for what he was pleased to term their damnable opinions. The first asylum mentioned in history is one erected by monks at Jerusalem in the latter part of the fifth century. The monks were indeed pioneers in this form of charity during the middle ages. In the fifteenth century Spain, then a center of learning, took the lead in providing for these people, although their provision was in many instances but a speedy preparation for death. The monks at Saragossa, however, seemed to have had the first faint conception of open air treatment for the insane to be found in modern times. As we view the institutions of the present day we are scarcely able to realize that not a hundred years have elapsed since persons of unsound mind were treated like wild beasts, kept under bolt and bar, manacled in cells and dungeons, and surrounded by poisoned and mephitic atmosphere; indeed in some cases the poor patients were exhibited in cages to the public at fixed rates, and were probed and tormented to gratify vulgar curiosity. Less than a century has passed since Pinel loosened the chains of the miserable occupants of the Bicetre, in Paris, and thereby inaugurated an era of emancipation almost equal in importance to that introduced by Abraham Lincoln. It would be a most interesting resume, did time permit, to pass in review some of the methods and expedients for treatment of the insane from the time of Pinel down to the present, but we must refer the interested reader to Mr. Letchworth's book.

In the period which has elapsed fron 1830 to 1850 the advances in the methods for caring for the insane throughout the United States were most distinct. The reforms attracted so wide attention in Europe that they were speedily adopted abroad, and our own methods were gradually surpassed; indeed so much is this the case that it has been asserted that our own country has failed to keep pace with the spirit of reform elsewhere manifested. If there is any truth in this charge it is pleasant to find Mr. Letchworth stating that the time is not far distant when our methods of caring for the insane will reach a higher standard than those of any other country. A greater part of the book is devoted to a careful study of the methods of individual foreign asylums. To a history of the world-renowned colony of Gheel some forty pages are devoted, which makes most entertaining reading, and from which the interested reader can secure a better idea than he can obtain from any other source.

The work concludes with a resume of exceeding great value in which all the peculiar defects and methods of dealing with the insane are considered at length. We hope to see this remarkable volume given a wide circulation, and especially are we anxious that the well-digested opinions and advice of its learned author should be given a wide acceptance. Written rather from the standpoint of a most intelligent and observing layman than from the medical expert's point of view, it is, nevertheless, the work to appeal to the lay reader, in some measure because it is devoid of technical terms, and in another way largely because it is written from the point of view of those who must support and maintain these institutions and who furnish the principal contingent of their patients. Not alone from a literary standpoint is the work to be commended but as a beautiful illustration of the bookmaker's art, since it is printed in large type upon heavy paper, is beautifully illustrated, contains many photographic reproductions of pictures taken for the author, and altogether forms a work whose internal and external attractions are well matched.

WE REGRET to be obliged to announce that Dr. R. A. Witthaus has resigned the chair of chemistry in the Medical Department of the University of Buffalo, which he had so ably filled for several years. Dr. Witthaus' engagement in New York makes it impossible for him to attend to his duties here. The chair has not yet been filled.

DR. GRANGER, of the Buffalo State Hospital for Insane, having resigned, the following changes in the staff have been recently made. Dr. A. W. Hurd becomes Senior Assistant Physician, Dr. H. G. Matzinger Second Assistant, and Dr. Bryant Third Assistant Physician.

Dr. J. W. Andrews, the Superintendent, goes abroad this month, on a brief and well-earned vacation.

THE Buffalo Medical and Surgical Association at its last meeting elected the following officers: President, Dr. A. A. Hubbell; vice president, Dr. M. B. Folwell; secretary, Dr. W. H. Bergtold; treasurer, Dr. F. E. L. Brecht; librarian, Dr. Lucien Howe.

We sincerely trust that the incoming president will succeed in doing as much for the society as did his predecessor, Dr. Van Peyma, and that the members will continue to evince their interest by activity in work, and promptness in attendance.

WE ARE pained to have to record the recent demise of Dr. S. W. Gross, of Philadelphia, who was stricken down in the prime of life and in the midst of a career of great professional usefulness. He was more than the "son of his father;" he was a man of distinguished attainment and broad culture, a fluent writer and a good surgeon. Had he lived to attain his distinguished father's years he would have rivaled him also in the comprehensiveness of his knowledge. His death is a great loss to the profession, and in more than one way.

Society Proceedings.

BUFFALO PATHOLOGICAL SOCIETY.

REPORTED BY DR. EUGENE A. SMITH, SEC'Y.

Regular meeting called to order by Dr. Rochester, April 19. The resolution offered by Dr. Eli Long at the March meeting, that eight members shall constitute a quorum for the transaction of business was adopted as an addition to the rules governing the society.

Dr. Hinkle then read a report of a case of inflammatory induration and ulceration within the larynx which had long resisted treatment. It was diagnosed by a New York specialist as Catarrhal Phthisis of the Larynx. Dr. Hinkle finally reached by exclusion a diagnosis of local laryngeal lesion depending on Lithaemia. He called attention to the fact that chronic laryngitis and naso-pharyngeal catarrh often find their causation in Lithæmia. Another case reported by Dr. Hinkel is that of a man of 45, who is a hard smoker and a steady drinker and who gave an uncertain syphilitic history, all secondary manifestations being absent. From this patient's larynx Dr. Hinkle removed a tumor the size of the tip of a finger. A microscopical examination by Dr. W. H. Bergtold, showed it to be new tissue of syphilitic inflammatory formation.

Dr. Park asked what laryngologists mean by catarrhal laryngeal phthisis which the essayist said he could not answer.

Dr. F. W. Potter emphasized the importance of recognizing constitutional conditions as the cause of local manifestations.

Dr. Van Peyma doubted the etiological effect of syphilis in the essayist's second case, and from his experience he maintained that rheumatism in pregnant women is extremly rare.

Dr. Jewett felt sure that seeming tertiary manifestations which yield to specific treatment prove syphilis even though secondary evidences were absent.

Dr. Rochester stated that he has observed tertiary manifestations are most liable to appear in organs that the patient most uses. He cited a case of cerebral gummata in a literary man, and the essayist admitted that his patient was in the habit of using his voice a great deal in his business.

Dr. Pryor presented a specimen of aneurismal dilatation of the aorta from a patient sixty years old. There were ulcerated atheromatores patches in the aorta with calcareous plates in spots, and the heart was hypertcophied and dilated. A second specimen showed distinct spots of marked ulceration in the aorta. Dr. Pryor also showed a lung taken from a patient who had hydro-pneumo-thorax, but he intends making a later detailed report of the case.

Dr. W. H. Bergtold presented specimens from a post-mortem which he had made at the General Hospital, with the following history : G. K., aged 28, German, admttted February 15, 1889. Had been a steady drinker for some years, and had had rheumatism.

On February 11th, while playing at cards he became very angry, felt his head swim, and fell from his chair. He was found, on being picked up, to have lost the use of his entire left side.

Entered hospital with motor paralysis of left side, sensation unimpaired, pupils sensative. He was mentally, somewhat slow and rather drowsy. Physical examination gave loud murmurs over precordial region at apex both on systole and diastole. With the latter the sound is louder, more prolonged, and also heard well at a point over the sternum opposite the heart's apex.

Bowels regular, appetite fair.

April 17th. Condition has remained about the same until this morning, when at " rounds " he appeared as well as usual, and wanted to sit up. At 9:45 A. M., (or fifteen minutes later) he was seen to go into a fit. Was unconscious, left arm and leg in a state of tonic spasm, with convulsive movements of the right side. Pupils equal in size, sensible to light, and coeneæ sensative to touch. Respirations 40–45, and pulse above 150. Heart's action very tumultuous. He continued in this condition for twenty minutes, gradually becoming weaker, and dying at 10:10 A. M.

Autopsy held twenty-four hours after death: Rigor mortis well marked, body well nourished; chest, abdomen and left shoulder covered with many small yellow maculæ; pus oosed from meatus. *Brain:* Dura and pia normal; Right carotid normal. In the left internal carotid at its junction with the circle of Willis was a large embolus, easily extracted and non-adherent. It was apparently of the same material as the aortic valvular vegetations found later. The central portions of the *centrum ovale majus* and *minus* were of the consistency of curd and on section a milky fluid exuded from the cut surface. This area of softening did not involve the cortex save at the inferior temporal convolution where it had extended to the cerebral surface. A cyst about 1.5 cm. in diameter was found in the cortex as the superior end of the left ascending frontal convolution. It was conical in shape with its base toward the dura and had no wall or limiting membrane proper. A cloudy serum filled the cavity.

Lungs.—Both œdematous, and markedly hypostatically congested. Middle lobe of right lung near its anterior edge was an infarct.

Heart.—Right cavity greatly dilated; tricuspid valve thickened and insufficient, with one leaflet fenestrated; pulmonary valves normal; left cavity also markedly dilated; mitral valves very thick and stenotic, free edges of leaflets had several atheromatous vegetations; aortic valves the seat of extensive atheromatous vegetative endocarditis, the edge of each leaflet was completely covered by these vegetations except about one-third of one from which a piece was missing. The embolus found in the left internal carotid fitted into the vacant place very closely.

Liver.—Congested, no infarcts.

Kidneys.—Congested, contracted, and contained scars of old infarcts.

Attention is called to the following points: that the patient had had rheumatism, that he had had a hemiplegia which dated from a sudden onset three months previous to death; that he had died suddenly in a convulsive seizure. For the left hemiplegia the extensive softening of the right centrum, coming probably from an embolus similiar in origin to the one found after death, is sufflcent cause, while for the convulsive attack the left internal carotid embolus is ample cause.

The case illustrates well a very interesting and instructive cycle, to-wit: Rheumatism, valvular disease; right-sided cerebral embolus, left-sided hemiplegia; left-sided internal carotid embolus, convulsion seizure, death.

Dr. Park interested the society with a set of "Before and After" photographs of a recurrent epithelioma of the side of the head for which he had operated. He also presented a specimen of fungous tuberculosis of the knee-joint for which he had performed amputation.

Dr. Gustav Pohl, with his application for membership, sent the following report of a case of tumor of the mediastinum with the specimens:

On March 1st, Maria S., aged 14 years, female etc., called at my office complaining of a swelling of her neck and chest. Patient was of ordinary size, robust, but somewhat pale. I found the thyroid gland greatly enlarged, the swelling extending over the upper portion of the chest. On auscultation I found heart sound normal but faint. Respiratory murmur scarcely audible on left side. Anterior portion of chest flat on percussion. Patient complained of cough, becoming more troublesome at night. Dyspnœa worse at night. Had just got over menstruating. Swelling came on about a week prior to seeing me. Never noticed it before. No other symptoms. I took it to be a swelling of the thyroid gland incidental to menstruation at that period of her age and prescribed a comp. iodine liniment. At a visit a few days later I found swelling worse and somewhat reddened. Under the application of hot flax seed meal poultices swelling was reduced to nearly normal. Heard nothing more of her until March 16th, when her father called on me and informed me of her death which occurred rather suddenly about 11:30 the previous night.

In an autopsy made 36 hours after death on removing the sternum and cartilages they were found to be adherent to their entire extent to a mass which completely occupied the anterior and middle mediastinum. The growth involved the thyroid gland, was adherent to a portion of the upper lobe of the left lung and also firmly attached to the diaphragm. The heart, large vessels and trachea were completely surrounded by it, resting in it as in a sack. The glands of the neck were unaffected on either side. The left lung was crowded entirely out of sight into a small space posterior to the tumor, but both lungs were free from any trace of disease. Liver and spleen normal. On both kidneys were found sarcomatous growths of the size of a walnut, and white in color same as primary growth. Kidneys somewhat congested. Ovaries contained several small sized cysts. Other portions of the body were normal. The new formation was of a fibrous consistence and of a gray white color and believe it to be a sarcoma of the mediastinum. The autopsy, being objected to by the mother, was made rather hastily and under close surveillance of the father, and the following specimens surreptitiously obtained, I now beg to present to this society together with the above history. Owing to the inability of the parents to converse in any other but their native tongue (Polish) I am unable to give a more complete history of the case, but would add, that so far as I could ascertain, no cancer was known to exist in any other member of the family.

Dr. Geo. H. Westinghouse also sent specimen and the following history of the case with his application for membership :

Mrs. Kaiser, aged 40 years, had six children. Never miscarried before. Last menses January 6–10. April 13th, pain and hæmorrhage for three or four hours. A short time before arrival ovum expelled entire. Cause of abortion, five weeks previously her husband and a friend wrestling frightened her. Pain and a little hæmorrhage for one day, then stopped. Last night she suffered from a chill, and dreamed her husband was dead.

Upon balloting both candidates were elected.

Dr. Hinkle mentioned a case of frequent sore throat which was cured by removing impacted cerumen from the ear. He remarked a reflex sore throat from ear trouble is much rarer than the converse.

CLINICAL NOTE ON SULPHONAL.

By DeLancey Rochester, M. D.

It is asserted of the new hypnotic, sulphonal, that it has none of the unpleasant after-effects, such as headache, weakness, disturbance of stomach, etc., that usually follow the administration of the other hypnotics. In this connection the following report will be interesting: Miss P., a young woman of about 30 years, a case of Basedaw's disease, has been very much disturbed for the last two years by loss of sleep in addition to the usual nervous symptoms accompanying her disease. As her rest had been greatly disturbed for a week, on Sunday, December 16th, she took 30 grains of sulphonal (Bayer's) at 10 P. M. and slept without interruption until 8 o'clock the next morning, when she was awakened by her sister. On attempting to raise her head from the pillow, however, she was taken with such violent pain in the head that she was forced to lay back again immediately. The headache was accompanied by great nausea, which was relieved by vomiting about one hour after she awakened. After the vomiting, the headache gradually passed away, but the patient felt great weakness and trembling of the legs throughout the day. Monday night she took no medicine and slept with one slight interruption from 11 P. M. until 7:45 A. M., Tuesday, when she awoke feeling better though still weak. She said she had not slept so soundly in two years as she did Sunday night, but that she would not wish to do so again if the after-effects were to be the same.

However, a few days afterward I persuaded her to try again, this time using 23 grains. The result was the same but in a milder degree. A week later she tried 20 grains and slept soundly for eight hours that night and the following night without any evil after-effect. In this case it is to be noticed that the sleep-producing effects lasted two nights, the best effect being produced by the smallest dose.

Correspondence.

LETTER FROM PHILADELPHIA.—NOTES FROM THE UNIVERSITY OF PENNSYLVANIA.

PHILADELPHIA, March 15, 1889.

Dr. Goodell has made an innovation this year, in performing laparotomies in open clinic, though he has for several years operated before smaller ward classes. During the session he has made about a dozen abdominal sections in the large ampitheatre before four or five hundred students, the temperature of the room being 70° or 75° F. Results have fully justified this departure from previous rules. Most of these operations have been ovariotomies and at two of them dermoid cyst were removed. One of his last sections was on a girl of sixteen from whom he removed a bilocular cyst of the left ovary containing sixty pounds of dark, " muddy " fluid.

It is interesting to note that Dr. McLean, of Detroit, has performed laparotomies in the clinics at the University of Michigan for some years though, as he himself said two years ago, contrary to the views of many of the profession.

The courses in histology and pathology are particularly interesting. Besides the usual lectures, Dr. Piersol gives each week a demonstration of histology by stereopticon views, and each month what might be called a microscopical soiree if it occurred later in the day. He takes up each time some particular apparatus, as for example the alimentary tract, exhibiting several slides for each organ so that the development of all the parts is shown from their most rudimentary embryonic state to that of their perfect functional activity.

Weekly demonstrations of pathology are given for the senior class, by means of fresh and preserved specimens. Post mortems are performed weekly by Dr. H. F. Formad, who is coroner's physician as well as demonstrator of pathology, and every member of the class is required to make at least one post mortem examination under his direction. Dr. Formad also instructs the seniors by sections in the essentials of practical bacteriology.

During the first year, each man mounts from eighty to a hundred histological specimens ; in the second year sixty or eighty slides of tumors, granulomata and other pathological lesions, and in the third year instruction is given in microscopical diagnosis.

CHANGES IN THE FACULTY OF THE UNIVERSITY OF PENNSYLVANIA.

Dr. D. Hayes Agnew, who has so long been professor of surgery, is delivering his last course of lectures. In spite of his venerable appearance, one soon learns that he is thoroughly modern in his surgery, having accepted the recent advances in antisepsis with a zeal which is seldom seen in men of so many years' experience in older methods. A picture is being painted for presentation to the University by the students, representing Dr. Agnew addressing the class at a clinic. The arena with the patient, anæsthetizer and other assistants, and one side of the amphitheatre are seen, while Dr. Agnew stands, knife in hand, and attired in his long surgical apron, describing the case to the students.

Dr. John Ashhurst, who leaves the chair of clinical surgery to succeed Dr. Agnew, is well known through his cyclopædia of surgery. He has a wonderfully minute knowledge of the history of his art and, while rather conservative, the results of his operations are a most convincing proof of the correctness of his judgment and of his surgical skill.

Dr. J. William White, the leading genito-urinary specialist of Philadelphia, succeeds Dr. Ashhurst. Dr. White has been demonstrator of surgery, clinical professor of genito-urinary diseases and has assisted Dr. Agnew at his clinics. In his service at the Philadelphia Hospital last Fall, Dr. White operated twice for paraplegia, exposing the spinal cord. In the first case, the patient had complete motor and sensory paralysis up to a sharply defined line which encircled the body just below the axillae. The operation revealed a pachy-meningitis. A portion of the dura was removed and from the relief of pressure on the cord, sensation was restored as soon as the patient recovered from the effects of the ether. In addition there has been a gradual, though as yet imperfect recovery of motor power.

In the second case, the paraplegia was due to kyphosis following dorso-lumbar vertebral caries. A successful result was prevented by the existence of extensive abscesses in front of the spinal column, of which lesion there was neither local nor constitutional sign during life.

Dr. Henry R. Wharton, assistant to Dr. Ashhurst, assumes the duties of the position which Dr. White leaves.

Dr. William Osler, professor of clinical medicine, has accepted the chair of practice at Johns Hopkins. Dr. James Tyson, Dean of the medical department and at present professor of general pathology and morbid anatomy, succeeds him. Dr. Tyson's manual of urinalysis is widely used throughout the country and his other works on allied subjects have made his name familiar as that of an authority on diseases of the kidneys.

Dr. Tyson's successor is Dr. John Guiteras, Assistant Surgeon in the U. S. Marine Service, at present stationed at Charleston, S. C. He also fills the chair of practice at the Medical College of South Carolina. Dr. Guiteras is a Cuban by birth and he graduated in medicine at the University of Pennsylvania in 1872. A. L. Benedict.

The publishers of the Medical Press will supply any book, no matter by whom published, post-paid on receipt of price.

Book Reviews.

QUESTIONS AND ANSWERS ON THE ESSENTIALS OF SURGERY, WITH A FULL DESCRIPTION OF THE HANDKERCHIEF AND ROLLER BANDAGES. BY EDWARD MARTIN, A. M., M. D. Pp. 314, with 90 illustrations. Philadelphia, W. B. Saunders, 1888.

This constitutes probably the most practicable quiz-compend in surgery, for students' use, with which we are familiar. As we glance over its pages we are delighted to see that the latest developments of modern surgical pathology have not been disregarded. It is such a comfort to find a work of this character, which in this respect is reliable that we are doubly pleased with it. The body of the work takes the form of questions with sufficiently full answers to satisfy the demands of any examiner or examination.

HANDBOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES. BY ARTHUR VANHARLINGEN, M. D. Second edition, enlarged and revised, pp. 410, with 8 full page plates and other illustrations. Philadelphia, P. Blakiston, Son & Co., 1889.

The wants of the practitioner as well as of the student have been kept well in mind in the preparation of this little manual. It is not a complete treatise and consequently nothing has been said about pathological anatomy and but little concerning the physiology of the diseases of which it treats. The arrangement is somewhat peculiar since the subjects are all arranged in alphabetical order. By such arrangement some conspicuous advantages are lost and some others gained. For the reader who knows exactly what disease he has to treat it is exceedingly servicable, since he can turn at once without an index to the subject which he desires to read, but for the student or junior practitioner who must arrive at his diagnosis by at best somewhat tedious process, the arrangement is not so handy. As a handbook of treatment it deserves almost unqualified commendation ; it has directions so brief and plain that there is no mistaking them. The special feature of the second edition over the first is in the addition of a number of illustrations some of which are original. Enough material has also been added to nearly double the original size of the book. Altogether it strikes us as a very serviceable and convenient manual.

THE PSYCHIC LIFE OF MICRO-ORGANISMS. A STUDY IN EXPERIMENTAL PSYCHOLOGY. BY ALFRED BINET. Translated from the French by Thomas McCormack. Chicago: 1889. The Open Court Publishing Company. Price 75 cents.

In this little book, with a title that is so curiously attractive that it begets thought, Binet the collaborator of Ribot and Fere, and one of the French School of Psychology, has presented the most important results of recent investigations into the world of Micro-Organisms. The subject is a branch of comparative psychology little known ; as the data of this department of natural science lie scattered for the most part in isolated reports and publications, and no attempt has hitherto been made to collate and present them in a systematized form.

The most interesting chapters are those on fecundation, which demonstrate the same instincts and vital powers to exist in spermatozoids as are found in animals of higher organization.

His researches and conclusions show, "that psychological phenomena begin among the very lowest classes of beings ; they are met with in every form of life from the simplest cell to the most complicated organism." The author contests the theory of the distinguished English scientist, Prof. George F. Romanes, who assigns the first appearance of the various psychial and mental faculties to different stages or periods in the scale of zoological development. To Binet there is an aggregate of properties which exclusively pertain to living matter, the existence of which is seen in the lowest form of life as well as in the highest.

The book contains a most entertaining and suggestive biological study of a very obscure subject and deserves widespread attention.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONERS INDEX, A WORK OF REFERENCE FOR MEDICAL PRACTITIONERS. Seventh year. New York, E. B. Treat & Co., 1889. Pp. 544, ($2.75.)

This volume of this well-known annual is divided into three parts for convenience of reference. The first is devoted largely to new remedies, and contains chapters upon massage and electro-therapeutics. A second part of the work contains a list of diseases arranged in alphabetical order, in which mention is made of every appropriate new therapeutic item of value which the literature of the past year has afforded. A third part of the annual contains miscellaneous information, such as a list of new works for the year, and a list of private asylums and homes for the insane, feeble minded and inebriates. Such a list as this latter we do not remember to have seen in any other work. The second part of the work seems to us possessed of peculiar value, since perhaps in no other work of its kind do we find as extensive information so happily condensed. The ground covered is not confined to medicine alone but includes surgery and all the specialties as well.

The book has been prepared under the supervision of a list of twenty-six editors, English and American, each of whom is eminent in his department. It therefore possesses all the value which authority and eminence of authors can bestow.

A MANUAL OF INSTRUCTION IN THE PRINCIPLES OF PROMPT AID TO THE INJURED, DESIGNED FOR MILITARY AND CIVIL USE. BY ALVA H. DOTY, M. D., New York, D. Appleton & Co., pp. 224.

This little manual is dedicated to the Surgeon-General of the New York State National Guard, Dr. J. D. Bryant, and has been compiled largely with a view to the exigencies and emergencies of military life. It is by no means, however, so limited in its scope; it is in effect a school text book on physiology plus a manual of first aid to the injured and a description of what to do in case of emergency. The only question which arises in our mind is as to the advisability of inserting so much elementary physiology in a work intended for the purpose to which this is mainly devoted; not but what everything which it contains is admirably adapted and copiously illustrated. If such a book as this could be substituted for the ordinary school text book on physiology, there would be about such teaching an element of usefulness which no book at present in use in our school possesses. We have in previous issues of THE MEDICAL PRESS called attention to the necessity for ambulance service and instruction in emergency in our National Guard. This little work exactly fills the bill in this respect and has been calculated largely for the use and needs of the young soldier. Its author is surgeon to the Ninth New York Regiment. It has already been accepted as the text book for the ambulance corps by the First Brigade and will be more widely adopted as it is the more closely examined. It has been compiled from the best sources and can be absolutely relied upon. We wish we might see it in extensive use.

A HANDBOOK OF PHYSIOLOGY, BY W. MORANT BAKER AND VINCENT D. HARRIS, OF LONDON; BEING THE TWELFTH EDITION OF KIRKE'S WELL KNOWN HANDBOOK OF PHYSIOLOGY. Revised and reprinted, with five hundred illustrations, New York, William Wood & Co., 1889. Buffalo, J. H. Matteson.

That editions of such a work as Kirke's Handbook should so rapidly succeed one another is the best indication that the work fills a perceptible want. This, the twelfth edition, contains a considerable number of alterations, especially in the sections on the blood, the heart and the muscular system. The chapters on the nervous system, the reproductive organs and on development have been practically reprinted. Some fifty new illustrations have been added and a difference in size of type permits the student to differentiate between matters of primary and secondary importance. We need scarcely to dilate on the peculiarities and advantages of this work. Its principal merit is perhaps its distinctness of statement and the facility of its arrangement. In this edition have been incorporated all the definite discoveries of the past few years and it may be accepted as both a reliable and authoritative work. It has perhaps another merit that it is not too long and that too much time need not be consumed in hunting up any desired information. It is admirably adapted for the student both at the commencement and termination of his career.

TRANSACTIONS OF THE ASSOCIATION OF AMERICAN PHYSICIANS, Vol. III. 1888.

The volume begins with the address of the President, Dr. Wm. H. Draper, in which he says: "We are met as friends in council, to present and compare the results of our individual experience, to discuss the questions which vex us, and to add something, if possible, to the enlargement of the science and the improvement of the art which constitutes the aim and purpose of our lives."

After carefully reading the transactions one is prepared to congratulate the association on having satisfied the ideal of its president.

In the way of "enlargement of the science," is a masterly contribution on the anatomy and pathology of the thynus gland, by Jacobi. This is profusely illustrated by excellent plates.

The relation between tropic lesions and diseases of the nervous system, is presented by Seguin and Wood, exciting an interesting discussion, which is participated in by Ord, Pye, Smith, Ferrier and Horsley, of London, besides Starr and Bowditch of this country.

In the direction of "Improvement of the Art," is a delightful paper by DaCosta, on the treatment of valvular diseases of the heart. If there is a presentation of this subject more philosophical, practical and beautiful, we have not seen it. The author points out the feasibility of combination of drugs which, by united action, oppose untoward effects, while determining results not to be attained by single remedies; and asks for further study in this direction. An article on the stage of convalescence in typhoid fever by Hutchinson, of Philadelphia, leads to an animated discussion as to the best method of feeding patients during this stage. Strangely enough very divergent views are expressed by the participants, and it is difficult to say whether the majority favor a strictly fluid diet for a prolonged or for a short period after the subsidence of the fever. To us it has seemed a matter no longer to be disputed that safety to the patient demands a strictly fluid, practically milk diet, for at least a fortnight after the cessation of temperature; and the prediction is ventured that this management will some day be recognized generally as a necessary routine treatment. It would seem to us that the views of Dr. Ord, which are re-inforced by the remarks of Dr. Kinnicutt, that, to a considerable extent, we should give in to the desires of our patients, as to the quality of food, is dangerous doctrine, the more likely to do mischief since eminating from such distinguished sources. One important fact was not developed, which is that when patients are allowed semi-solid food during the fever, they are not so likely to suffer from an early return to solid food as are those who have been kept on a strictly milk diet until convalescence has begun. In the latter case, when the digestive tract is unaccustomed to solids, such foods are the more apt to do harm. It is to be deplored that the transactions of this society are not sold by subscription, or in some other way introduced to the rank and file of the profession who particularly need these contributions which at present remain out of reach of the many.

C. G. S.

Current Medical Thought.

THE PREVENTION OF MAMMARY ABSCESS.—Miall says that when mammary abscess is on the point of forming, he has frequently seen all the symptoms disappear in a few hours under the influence of fomentations with hot water and carbonate of ammonia. He uses an ounce of the carbonate in a pint of water, and, when solution is accomplished, the temperature of the fluid will be hardly too high for fomentation to be commenced with cloths dipped in the liquid. He applies them from half an hour to two hours, at the same time protecting the nipples. He has often had immediate relief, and seldom requires more than three applications.—*Medical News.*

CRUDE DRUGS AS COMPARED WITH ALKALOIDS.—There is now much discussion, says our Paris correspondent, as to whether cardiac medicines should be given in the form of an alkaloid, or whether the preparations of the crude drug should be used. Huchard, Dujardin-Beaumetz, and many others believe that they have obtained better results by the use of the drug itself, while See and his followers prefer the alkaloid. The latter hold that an alkaloid is always the same, while the virtues of the drug are uncertain and depend upon the age, etc., of the plant when gathered, and upon the time it has been kept before being used.—*N. Y. Medical Journal.*

FLUSHING THE PERITONEUM.—The *British Medical Journal* calls attention in an editorial on this subject to a recent paper by M. Polaillon, who narrates two cases where he utilized this procedure with untoward results. In one case the patient died, and in the other the patient suffered from profound syncope.

The first case was one of suppurating oophoritis on the left side and double salpingitis. Firm adhesions had to be broken down. The peritoneum was flushed with hot distilled water, and during the process profound syncope with suspension of respiration took place. After making a tracheotomy wound in the patient's neck, rapid amelioration of the symptoms occurred.

The second case was one where a large cyst had to be shelled out of the broad ligament. In order to flush out a considerable amount of effused blood, the operator employed distilled water delivered through a glass canula heated to about 99° F. This was followed by alarming symptoms on the part of the patient. The respiration became rapid, feeble, and finally ceased, and it was only with the utmost difficulty that the patient was finally saved. In regard to the amount of water used, M. Polaillon states that he first poured in about half a gallon of hot carbolized water, and as it came out strongly tinged with blood, more was used and accidentally at a higher temperature than that at first. The pelvis being full, the water reached the upper part of the abdominal cavity. It was at this moment that respiration ceased. The operator believes that the stimulus of the hot water touching the diaphragm or solar plexus caused, by reflex action, the arrest of respiration and syncope. He suggests in cases where flushing is necessary that the patient be raised up slightly so as to have the water gravitate below. The operation was done under the influence of chloroform.

THE TREATMENT OF URETHRAL STRICTURE BY ELECTROLYSIS A FAILURE.— Dr. E. L. Keyes, after a faithful trial of electrolysis in stricture, pronounces the method a failure. In a paper on this subject, published in the *New York Medical Journal*, he says that a widespread belief exists in the community, lay as well as medical, that material progress has been made of late years in the use of electricity as applied to the cure of urethral stricture. This belief includes the three presumptions:

1. That any one, by following rules, may use the method successfully.
2. That electricity does no harm to the urethra.
3. That stricture cured by electricity is dissipated by absorption, and the urethra remains permanently open.

There are no foundation for these beliefs. Dr. Keyes had occasion to observe eight typical cases, in which the method, as advocated by Dr. Newman, was given a fair trial. In one of these cases, Dr. Newman himself applied the electricity. All of the cases proved to be failures. Dr. Keyes concludes his article as follows:

"I may state that electrolysis with a very mild current — I prefer to put it at less than two milliamperes and a half — does no harm, in fact, does nothing that I can appreciate, and does not interfere with the benefit to be derived from ordinary dilatation. I believe that a strong current is full of danger, both immediately from irritating effect and ultimately from cicatricial effect; and that employment of the negative pole does not prevent this.

"My study of the subject and the experience it has brought me, digested with all the impartiality I possess, lead me to state that the allegation that electricity, however employed, is able to remove organic urethral stricture radically, lacks the requirement of demonstration. The confidence of its advocates that it will radically cure organic fibrous stricture is, in my opinion, due either to the combined credulity of the patient and imagination of the surgeon, or to some special but fortuitous act of Providence, upon the co-operation of which, in the case of his own patients, the general practitioner cannot with any confidence rely."—*New York Medical Record.*

ERUPTIVE FEVERS—TREATMENT.—These fevers have so many points in common as to fairly entitle them to constitute a distinctive group. They are variola, vaccina, rubeola, scarlatina, varicella. Each, for cause, has a specific virus or toxic agent; a stage of incubation, rigor, pyrexia, eruption, desquamation; is self-limiting.

The point which we wish to make clear in this brief paper is: the imprudence and danger of attempting to abort, cut short, or *cure* any one of the stages or conditions of above-named fevers. Mistakes in this direction have doubtless had much to do with the various sequelæ and mortality attending these affections. Should any one of the stages manifest great intensity or violence, so as to result in great bodily discomfort, we should interpose palliative modes, but with no purpose to abort or suddenly arrest any part of the various stages.

If we suddenly arrest a mild fever, we shall most likely prevent the eruption. If we suppress or prevent the eruption, local. visceral, internal complications will most likely result. Even the process of desquamation should be allowed free course, as the concluding stage in the probable effort at septic elimination.

As an illustration of the idea we wish to convey, we should say, the best plan of treating scarlet fever ever adopted, in mild cases, was what was known at the time (twenty-five years ago) as the bacon skin treatment, which simply consisted in smearing the skin, every three or four hours, with a piece of salt fat pork skin. This plan had the advantage of a masterly inactivity, while it amused and employed both patient and nurse. It had the additional advantage of being the very best mode of allaying the distressing pruritus usually so prominent during the stages of eruption and desquamation. Of course, while pursuing a course of expectancy and noninterference, it will be eminently proper to display and administer some placebo form of administration, to meet the usual demand for treatment.

As before intimated, great violence and complications may require and should receive suitable, prompt treatment; but the mild forms should be interfered in none of the stages. The process is nature's effort to eliminate an offending toxic agent.

We think the sequelæ to many of these fevers the result of officious heroical efforts to abort or suppress. These sequelæ seem much less frequent than formerly, probably due to more conservative modes in management.

My favorite mode of treating these fevers is a hasty, daily warm bath, followed by a free application of any deodorized warm oil to the skin, with any placebo prescription to employ the nurse and family.—Dr. W. A. Edmonds, St. Louis, Mo., in *Medical Brief*.

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ELECTRICAL APPARATUS FOR PHYSICIANS.

By W. E. Ford, A. M., M. D., Utica, N. Y.

[Being an Abstract of a Lecture delivered, by invitation of the Faculty, before the Medical Class in the University of Buffalo. Session of 1888-9.]

The revival of interest in electro-therapeutics and the adaptation of electricity to certain new uses has made it necessary to revise and to modify the apparatus for its successful application. So far as the faradic or induced current is concerned little if any modification of the instruments formerly used is necessary. Whatever change is made seems to be in the direction of simplifying and cheapening the machines. It is not necessary that portable faradic batteries should have an elaborate device for reversing the direction of the current, for it is always an alternating one, and it is therefore a matter of little consequence if any, which pole is selected for use. It is not known either that a second or a third induction coil alters the therapeutic effect of the current or that the rapidity of the interruptions is of great consequence. The simpler the battery therefore the better. So far as static electricity is concerned there has been no improvement in the machines for its use and the benefit of charging the surface of the body with this current is of such doubtful utility that little need be said about the apparatus. It is not known that static electricity penetrates the deeper tissues and hence its use must certainly be limited.

In the uses of galvanism however the greatest change has taken place within two or three years. The stronger currents are applied for entirely new purposes and the tendency is toward the analysis of the elements of this current and a clearer definition of their possibilities. One cannot work successfully with the batteries that have been commonly sold to physicians for years past. It is not probable that electricity will be of much service to the general practitioner until batteries can be bought for a reasonable sum that will maintain a large current for a considerable time without the necessity of too much personal care. The instruments of precision so much talked about now-a-days are obtained easily enough, but the batteries are not easily found. The two fluid batteries requiring from 50 to 80 cells are expensive, and, to physicians remote from large business centres where electrical supplies can be easily obtained, are practically out of the question. We shall never know, however, the exact truth regarding the value of electricity until it comes into common use by the general practitioner. The talk about accurate dosage and the set rules for the manipulation of delicate resistance apparatus and galvanometers are largely misleading. It will never be possible to give a measured dose of electricity as one gives a weighed dose of medicine. The density of the current, the area of its diffusion, the resistance of certain tissues and the ready conductibility of certain other tissues, together with the slight differences in the moisture of the skin where the electrode is placed, are elements that can never be accurately estimated beforehand. We must judge therefore by the effects produced, while the various conditions for which it is used will always require careful observation. Ohm's law, which is quoted as the standard by which all batteries are to be tested, may not apply with equal force when the effect is upon living tissue and not upon some mechanical contrivance. I have for a long time been convinced that a current generated from a few large cells, having considerable volume therefore and little tension, acts very much better in removing pelvic exudates and effusions than does a current of smaller volume generated from a large number of cells connected up in series, each current causing the milliampere-meter to mark the same figure. I have been disappointed too in the action of the former current when long distances were to be traversed, as for instance the whole length of the spinal cord. In such cases the latter current has the requisite voltage and not sufficient volume to burn under the electrodes. It would be better therefore if the relative proportion between the volume and the intensity of a current could be changed at will so as to give a wide range of usefulness to the same instrument. This cannot well be done in the stationary double fluid batteries, nor in the current from a dynamo, and I think we shall have to admit that the simplest form of bichromate battery is the best all round instrument. Until instrument makers begin to make these with cells large enough to maintain a steady current for a long time and with an adjustment so that the zincs and carbons can be immersed to any desired depth thus changing the volume of current and regulating it without the necessity of resistance coils or water rheostats, physicians will have to make their own batteries. Most of the work with large currents must always be done in a hospital or in the office of the operator. There is no battery small enough to be conveniently carried from house to house that will generate a very large current without too much attention and expense to the apparatus. I do not discuss here the so called dry batteries for I have never seen any such work satisfactorily for a long time. The best portable battery is the 32 cell instrument made by the Galvano Faradic Company, of New York. Hard rubber cups for holding the fluid should never be used. They do not last as long as glass ones. For the office 16 one quart large mouthed glass jars arranged in a box, and over them a sliding wooden shelf in which the zincs and carbons are fastened, the shelf being raised and lowered by means of a leather strap attached to a roller above the whole, enclosed by a tightly fitting cover, make a satisfactory battery. The zincs should be at least eight inches long and four inches broad. If the zincs are to be cut for the purpose, rolled zinc and not the commercial must be used. The elements should be connected up in series and a simple switchboard used on the outside of the box to govern the number of elements. A crank on the outside of the box attached to the windlass within completes the machine, which can be easily made by any ordinary carpenter, while the zincs, carbons and glass jars can be obtained at any electrical supply store at a cost of about a dollar for each complete cell. This battery will not run down with ordinary use and would probably last a general practitioner about two or three months without refilling with fluid. Coupled up in pairs it could be easily changed into a most powerful cautery apparatus.

FUNCTIONAL ALBUMINURIA WITH REPORT OF A CASE.

BY ELI H. LONG, M. D., BUFFALO. N. Y.

[Abstract of a paper read before the Pathological Society.]

The main characteristics of reported cases are as follows: Albumen in variable amount is usually found after exercise, sometimes during digestion, never in the morning before rising. The urine shows no other essential change, and the general health is good. The amount of albumen is usually small, often the slightest trace.

Dr. Grainger Stewart has reported a remarkable result of observations on a number of apparently healthy persons, finding albumen in the urine of nearly one-third. It is evident that a profitable study of functional albuminuria should exclude cases which date from a nephritis, or from scarlatina or measles. There is reason to suspect structural disease in such. Cases also are reported where hæmatinuria is present at one time and albuminuria simply at another. If the histories of Dr. Stewart's cases were at command they might not show cases entitled to be considered functional so common.

One view of the significance of this condition is thus stated by Johnson:* "A frequently recurring albuminuria, if neglected, will almost invariably result, though it be after many years, in structural degeneration of the kidneys."

Another view is expressed by Pavy† in these words: "After these cases have now been recognized and their progress watched for a considerable number of years, experience has not shown that the disposisition exists to pass out of their original form into the class associated with textural disease."

Dr. Tyson‡ believes "that it is sometimes possible to establish that a man whose urine regularly contained albumen had no change, or tendency to change, in the kidneys."

As to causes of the condition, many are given but none proven. It is more common in youth than later. Faulty digestion, diet rich in proteids, high arterial tension, cold bathing and active exercise are among the causes mentioned, but their influence varies in different cases.

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* *Lancet*, January 7, 1888.

† *Lancet*, April 14, 1888.

‡ *N. Y. Medical Journal*, December 8, 1888.

Ralfe* would attribute to the renal epithelium a two-fold function—selective and metabolic; the one pertaining to excretion, the other to the conversion of the albuminous elements concerned in its own nutrition, and probably also of any effete albumen, into urea. The latter function disturbed or overtaxed might give rise to albuminuria. This might result from excessive blood solution.

It is evident that we must look either to the blood, the circulatory system, the kidneys, or the nervous system for the cause, but the subject awaits further observation and experiment to allow of positives. If the blood furnishes the cause, is it improper nutritive supply, an excess or unusual form of albumen, or excessive hæmolysis? If the circulation is at fault, is it due to high arterial pressure, or to stasis? Is the condition general or local? If we look to the kidneys or the nervous system, the cause is equally problematic.

Dr. Julius Schreiber† has communicated a very interesting series of experiments. He was able, by moderate compression of the thorax, to induce albuminuria in twenty persons out of twenty-six in one series, and in eight out of ten in another series. The degree of pressure employed was always short of dyspnœa or compensatory effort; indeed, when dyspnœa was induced the experiment failed. The time necessary for the induction of albuminuria varied, being in some cases less than two minutes. The explanation offered by Dr. Schreiber starts with the induced disturbance of the ordinary conditions of pressure in the thorax, and the corresponding embarrassment of the pulmonary circulation. This is supposed to extend speedily to the systemic circulation and kidneys, and albuminuria to result.

The case to be reported is that of a lady twenty-eight years old, married, mother of two children. Family history good except neurotic. She had measles in childhood but not scarlatina. Has never had any severe illness, is in good health, and digestion is normal. There has never been the slightest indication of any organic disease, unless the albuminuria be so regarded. The condition was incidentally discovered about two years ago, before her last gestation. The following results of testing the urine are submitted:

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* *Lancet*, November 17, 1888.

†Archiv fur experimentelle Pathologie und Pharmacologie, xix., xx.—1885-6.

Specific gravity. One hundred tests showed the specific gravity below 1015 only 8 times. The specific gravity of the whole quantity of daily urine taken on seven days, was never below 1020, and the average for the seven days was 1024.

Quantity. The average daily quantity for the same seven days was 800 cc.

Albumen. By the cold nitric acid test (Hiller's) 34 samples of urine voided upon rising in the morning showed the very faintest trace only once; 27 samples between breakfast and dinner showed albumen present in 24 and absent in 3; 27 samples between dinner and supper showed albumen present in 21 and absent in 6; and 27 samples after supper showed albumen present in 18 and absent in 9.

For two days each hour's voiding from 7 A. M. to 10 P. M. was tested for albumen. The showing for the two days did not correspond except that the maximum of albumen was excreted after rising in the morning, before breakfast, about noon, and between 9 and 10 in the evening. It is evident from this that the digestion is not a causative factor here. The remarkable feature of this case is that during the gestation, which occurred since albumen was first discovered, 14 samples at different periods and at different hours of the day in no case showed albumen. These were tested by heat and nitric acid. In the absence of pregnancy albumen was always found by Heller's test during the forenoon, and often in sufficient quantity to respond to the heat and nitric acid test.

Microscopical. Occasional examination did not reveal any casts. Oxalate of lime was frequently present, and sometimes in considerable quantity, in the urine voided upon rising in the morning. No relation seemed to exist between the presence of this and of albumen.

The arterial tension is not high, as shown by the sphygmograph. So far no conclusions can be established from the study of this case, but it shows that in this instance, at least, faulty digestion and high arterial pressure (unless local) are not causative factors.

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A CASE OF BRAIN ABSCESS.

BY E. E. DAVIS, M. D., FORESTVILLE. N. Y.

[Read before the Lake Erie Medical Society.]

MR. PRESIDENT AND GENTLEMEN:—I have a case to report to you which has been of unusual interest to me and to the other physicians who have seen the case and tried to relieve the little sufferer. I report it to show how easily we may be mistaken in diseases within the cranial cavity. The case was a boy, seven years of age, of sanguine temperament, light complexion and hair, large head with rather small body, of active habits. Parents healthy. On the mother's side there is tubercular trouble, several dying from this cause. On the father's side there have been brain difficulties.

The boy on the day previous to his sickness played very hard, jumping from a fence, turning summersets, striking on the head and shoulders in a hard snow drift. He had also been drawn around by his feet by other boys, and some that saw them say they drew him down the school house steps some six or seven in number. On this same day he ate largely of chicken, which on the day following was vomited without being digested.

Doctor Meeder was called to see the boy on March 13th, found him very feverish, gave him some simple remedies and did not expect to call again. The patient was restless all night and in the morning the doctor was summoned again. He found him very delirious. The boy seemed to think he was at play, would laugh heartily and pat every one on the back as if playing some game. Then he would throw himself from one side of his crib to the other; so that it needed two attendants to hold him. He would repeat his lessons and long passages of scripture; when spoken to he would give an answer of some kind.

The doctor thought he could control this delirium with bromides, and gave large doses of bromide of potassum; at the same time giving a dose of calomel, followed in a few hours by castor oil, which caused severe catharsis through the night. I was called in during the evening, found the case the same as stated only much worse than in the morning, the pupils being largely and evenly dilated, tongue coated white with dark red center, sordes thick upon the teeth and lips; no tenderness in any part of the body; temperature could not be obtained. The child had the appearance of one with acute indigestion although many of the symptoms of that trouble were absent. We gave, hypodermically 1-12 grain of morphia, which soon gave him rest until morning.

Next morning (15th), the delirium returned, morphia was again used and again gave him rest for a few hours. Dr. Shaw, of Eden, was called in consultation with us on this day. Dr. Shaw looked upon the case as a serious one, and as he expressed it "thoroughly masked," he could detect a tenderness at the base of brain, the boy giving evidence of pain when upper portion of spine was pressed upon. He advised the use of ergotin, with morphia to quiet, nourishing the patient as much as possible. Temperature on this day, 100° in morning 102° in evening, pulse varying from 80 to 120. There was a peculiar hesitancy to the pulse, at times it was intermittent; breathing was very irregular, often very slow and again very rapid, not at all in unison with the pulse. On the morning of the 16th he appeared better; no delirium; had rested well through the night after having morphia in evening. His symptoms gradually improved, except that he was very sleepy all the time and not inclined to talk, his appetite grew better, tongue became clear, bowels normal: also temperature and pulse became normal on the 26th to 28th, although he seemed to gain no strength. On March 30th the doctor was again called, finding the boy rapidly growing weaker. On April 1st temperature again 100°, pulse 96, and weak, respiration labored. April 3d patient comatose most of the time, with partial paralysis of right side, swallowed with difficulty; pupils dilated, right one slightly the larger; would answer yes or no to some questions with difficulty; had no control of bladder or bowels; pupils contracted by lamp light.

On April 5th complete coma, jaws set, eyes rolling sideways, sweat at times profusely; convulsive symptoms in morning which increased during the day, extending over the whole body; kept under control by morphia. On the 6th he died in complete coma.

We examined the brain within one hour after death, and found the posterior portion of the cerebrum somewhat softened; from 6 to 8 ounces of fluid escaped from the ventricles of the brain. As we turned the cerebrum backward we found just under it, near the optic cornmissure an abscess, containing about one ounce of pus; this abscess extended backward to the medulla, burying itself low down in its substance. The brain otherwise appeared in a healthy condition.

What, now was the cause of this trouble? Was it tubercular or did it come from the rough handling of the boy in play? I think many of our diseases of children come from over exertion at play.

Clinical Lecture.

A CASE OF TRAUMATIC DURAL EPILEPSY, WITH OPERATION FOR ITS RELIEF.

From the Surgical Clinic of

PROF. ROSWELL PARK.

[Delivered at the Buffalo General Hospital, January, 1889.]

The young gentleman whom I bring before you, living at Suspension Bridge, was first referred to me the latter part of July, 1887, by Dr. C. R. Jewett of this city. The history given me was that when two years of age he sustained a compound comminuted fracture of the skull from the kick of a horse, the injury being at a point underneath the scar which I shall show you, located at the left side of the skull near the junction of the parieto-occipital suture and the parietal ridge. After the injury he was unconscious for a number of hours; he was operated upon at the time, and a number of fragments of bone were removed, after which he made a rapid recovery. From that time he has been well, though not robust in health, save for the epileptic attacks which I shall describe to you. When a school-boy about 12 years of age he had, as nearly as he could remember, his first epileptic seizure, which was very slight. From that time until six months ago he had them occasionally, but never lost consciousness. Within the past six months, up to the time when I first saw him, his seizures became more pronounced and frequent, averaging, at least, one a week, and during some of them he has totally lost consciousness. He has no aura that he can describe, and no bad habits. He is perfectly temperate; his bodily functions seem to be all regularly performed. At the spot of the injury is found an irregular defect apparently of the size of a silver half dollar, which is evidently closed by a tough membrane and covered by hairy scalp, with a permanent scar which can be seen to pulsate. There is a little sensitiveness around this region but nothing marked.

At the time of his first visit to me I advised an operation, which was at first agreed to and then postponed, since an interval of two or three months elapsed during which he had no seizures at all, and he deluded himself into the idea that he had been frightened into a recovery by the thought of an operation. It now appears that by October of 1887, the fits began to recur and soon became as frequent as before. By the middle of 1888 they were worse than ever. Fits of petit mal were more common than of grand mal. During December of 1888 he had seizures on the 3rd, 4th, 9th, 10th, 11th, 14th, 18th, 26th, 29th, and 30th, those of the 18th, and 26th, being very severe. During most of the others he could hold a book, he says, and not drop it. Questioning again to-day, I can get no account of any aura save an indefinite sensation of gasping for two or three seconds before the seizure comes on. I have taken particular pains to gather from the family physician and his family as accurate accounts as possible of his behavior during seizures. I learn that all his limbs are alike involved, and that there is absolutely nothing in his history or his condition at any time pointing to any localized lesion of the cerebral cortex. There is no history of a family neurosis; his mother died of cancer and his father of carbuncle. Upon careful examination of the head to-day, I find nothing save the bony defect which I noted 18 months ago. This scar is over the center for word-deafness or sensory aphasia and for vision; consequently, we can scarcely expect any history of spasm or paralysis of the truncar muscles or those of the extremities. His speech is perfect, there is no hesitation in his utterances, and nothing about his case points to lesion of the cortex or the centres. What then is the trouble? You remember that cases of traumatic epilepsy are to be divided into those of dural origin and those of cortical origin. Bear in mind that the dura mater is abundantly supplied with sensory filaments from the fifth pair, and that by virtue of its free nervous supply it serves as a frequent source of reflected epileptic convulsions, and that in these cases we must not expect to get the peculiar features which distinguish convulsions of cortical or Jacksonian lesions. I have prepared a brief tabular summary of the most conspicious features of each of these forms which I will put upon the board in order that you may contrast them.

EPILEPSY.

Dural.	*Cortical* (Jacksonian).
Spasm on same side as lesion, or most marked on that side.	When lesion is limited spasm is on opposite side.
Spasm tonic, with large movements involving both limbs.	Spasm more often clonic than tonic, and involving special groups of muscles.
Unconsciousness common.	Unconsciousness rare.
Quick conjugal deviation of head.	Conjugal deviation of head not customary.

Reasoning from the points summarized in this table, I have concluded that in this case we have to deal with lesions almost entirely confined to the dura and that the cortex is but slightly implicated, if at all. If this be the case, internal treatment can avail only so far as it obtunds reflex sensibility and paralyzes the most active cerebral efforts.

He has come to us now with his mind made up for operation, and desires only that it be thoroughly done. As you see, he has been prepared for operation by having the scalp carefully shaved, and I may add that he has been wearing for a day or two a moist antiseptic compress by which I have endeavored carefully to disinfect the skin of the scalp. You will see now what you could not see unless the hair had been shaved, that the scar of the original injury and operation stands out as a very tough cord, raised above the surrounding surface, and as large as my little finger would be if split in halves. It is eight centimetres long, and is met at its middle by another half as long, placed at right angles to it. These cicatrices are firmly adherent to the tissues beneath, and I have determined to completely excise all this old scar tissue, superficial or deep. Superficial incisions, therefore, are so planned as to accomplish this object, and as the knife goes in with great difficulty you will realize what peculiarly firm fibrous tissue we have to deal with. After a severe manual effort these two scars have been completely excised, they having been adherent not only to the bone but especially to the tough membrane which replaces the bone over the irregular area whence it has been removed. Now on endeavoring to dissect away this membrane, I find that it is so firm and tough that it is only after chiselling away a little bone at one margin of the opening and insinuating the point of an elevator underneath it, and then working partly with a stout knife, and partly with the chisel and mallet, that I disengaged it around the margin of the opening. Now after complete exposure of the bony defect, you will observe that it presents an area very nearly the size of a silver dollar, being four and a half centimetres in its longest and three centimetres in its shortest diameter. Having freed the scar tissue, I still find that I cannot lift it out of its place, and a little investigation shows that it is intimately adherent to the dura mater beneath. Just these adhesions I had expected to find and they easily explain the phenomena of dural irritation which have led to his reflex epileptic disturbances. Accordingly I cut with scissors through the dura mater, and by keeping the scissors close to the bony margin I have cut out an irregularly circular piece of dura of practically the same size as the membrane above alluded to; but now undertaking to remove this, I find it is quite intimately, though not firmly, blended with the pia mater beneath, and it is only by use of gentle force that the dura is separated from the pia. Having peeled this entirely off, you see, beneath, the surface of the cortex covered by a somewhat lacerated and bleeding pia mater. At some points the pia has been torn from its surroundings and was removed with the portion of dura above alluded to. Now as we observe the excised cortex thus irregularly covered, it will be seen that it presents a dusky and abnormal appearance whrch is not at all like that of a healthy cortex, and is not at all to my liking. I have become so impressed with the need for radical measures if we attempt anything at all in such cases, that I shall now take a sharp knife and slice off from the brain all that part which presents at this bony opening and which has already protruded above the level of the external table. After removing the slice of cortex, you will note that three small blood vessels spurt their little streams quite vigorously. These are arteries in the folds of pia mater, and each one of them I will catch with snap forceps and tie with fine catcut. After checking this bleeding, there continues to be a little oozing from the cut surface of the brain. This I will speedily check by spraying upon it a little five per cent. solution of antipyrine.

You see that within one minute it has all ceased. Now, in order that there may be no sharp spiculæ of bone around the margin of the opening in the skull, I take the burr of the surgical engine and by its aid smooth off every projecting spicule or rough point. I further bend a probe at right angles and pass it around beneath the dura, in order that any slight adhesions between the pia and dura beyond the range of vision may be severed. A few trifling adhesions are thus separated. All little tags of loose tissue having been carefully removed and all bleeding checked, there remains nothing to do but to close the wound. The excision of the old scars has necessitated the loosening of the scalp for a little distance all around the opening, in order that it may be more easily made to slide into position and be there retained by sutures without undue tension. You will observe that the scalp is made to cover the freshly cut brain surface. This one must do simply because no other covering is afforded. If this operation has been carefully and antiseptically performed, there will be but very small resulting blood clot beneath the scalp wound and there will be no opportunity for such a dense and extensive organized mass of cicatrical tissue as was present before. In this way I hope to avoid all possible cortical irritation in the future. Drainage will be effected by the introduction of strands of catgut which I shall probably remove at the first dressing, day after to-morrow. You will note how carefully every detail of antiseptic practice has been carried out, and I may say to you that we have not the slightest anxiety about the patient's condition, but expect him to get well with little or no disturbance.

NOTE.—The wound was dressed on the second day and perfect primary union was found. The highest temperature recorded was 102 the previous evening, which was regarded simply as an item of surgical fever. From this time it rapidly declined, and in two or three days fell to normal, there to remain. One week from the day of the operation, patient was walking about his room, and in 16 days left the hospital as well as he ever had been, and without having had the slightest indication of any epileptic or convulsive disturbance.

The patient has been very recently heard from (May 1, 1889), and reported himself as almost well. He says he has had a few very mild seizures, but considers himself as practically recovered.

DISCUSSION ON ACUTE LOBAR PNEUMONIA.

Held in the Pathological Society, May 17, 1889.

ACUTE LOBAR PNEUMONIA IN CHILDREN. BY IRVING M. SNOW, M. D.

The other gentlemen taking part in the discussion will undoubtedly describe the pathology, bacterology and general picture of pneumonia, and I will therefore only briefly mention wherein the disease in childhood presents symptoms not found in the pneumonia of mature life, and discuss some obscure points in the differential diagnosis of pulmonary diseases of infancy.

All modern observers agree that lobar pneumonia is sufficiently common in young children, being slightly more frequent after the second year than before. Great confusion formerly existed between catarrhal and croupous pneumonia and collapse of the lungs, and doubtless many cases of death, even now returned under the title of pneumonia, are of the catarrhal rather than the croupous type. The vital statistics of Buffalo for 1888, show 187 deaths, under three years, from pneumonia. It is however probable that most of these deaths were due to lobular pneumonia. A striking feature of infantile pneumonia is that it attacks both sexes with almost equal frequency, differing from the pneumonia of adult life, which shows a marked predilection for men, thus showing us that pneumonia is an infectious disease. Nevertheless the influences of alcoholism, exposure and irregular life, apparently play an important role in its causation.

The morbid anatomy of the lung in pneumonia of children differs little from that of the adult, save that the hepatized lung presents a more finely granular appearance and that pleuritic inflammation is an almost never-failing symptom. It may be easily distinguished from collapsed or carnified pulmonary tissue. Both pneumonic and collapsed lung present an induration of tissue and sink in water. Collapse of the lung is never accompanied by pleurisy. The lung may be reinflated and when cut presents a smooth surface life muscle, differing from the elevated granular aspect of hepatization.

The onset of the disease is usually sudden. In place of the prolonged chill common in the adult, children are often seized with a convulsion, which however does not often recur, or persistent vomiting may usher in the disease, the high temperature indicating that the gastric disturbances are not due to simple indigestion. A so-called cerebral pneumonia has been described which by intense headache, delirium, strabismus and convulsive seizures closely simulates a meningitis. These serious symptoms commonly occur in pneumonia of the apex, and although often evidently due to high temperature, have been ascribed to other causes, as to pressure of the exudate upon the large veins of the neck, impeding the return of blood and causing congestion of the brain, and to irritation of the cervical sympathetic which lies near the hepatized lung. Eclamptic symptoms affect chiefly rickety infants who suffer from delayed dentition. The pain in the side so common in adults is often apparently absent in children. It is true that the little patient by grimaces and by moans of pain may show that it is in great distress, yet to locate this pain is a difficult matter, as even in children able to talk, the pain is often referred to the sound side or even the abdomen.

Cough may be absent in the cerebral type, yet when present it brings with it no expectoration, the sputa being swallowed, yet strange to say, the characteristic pneumonic expectoration has never been recovered from the vomited matter or the stools. Children under five seldom expectorate. The ability to expectorate, like the accomplishment of blowing the nose, is attained earlier in some children than others.

In infantile pneumonia the breathing is much hastened, running up to 60–80–100 in the minute. Very slight diagnostic importance can be attached to rapid breathing, as any feverish attack will accelerate the respiration. In pneumonia it may even assume the Cheyne-Stokes rythm without indicating tubercular meningitis.

The pulse is very rapid and occasionally is irregular. Pulsation at the epigastum in any respiratory disease of children is a sign of great danger, indicating a laboring and dilated right ventricle. In taking the pulse into estimation the ease with which a child's pulse is accelerated by psychical influences must be remembered. Rilliet and Barthez describe an eruption in children with pneumonia, an erythema covering the body and quickly disappearing. This I have never been fortunate enough to see.

The difference between the physical signs found in the pneumonia of young children and adult life is fairly great. The crepitant rale upon which so much emphasis is laid can seldom be heard. I however have repeatedly found it in the pleurisy of children.

Of course the physician called to a suspected case of pneumonia at once proceeds to auscultate and percuss the lungs. However he will often miss the well marked dulness, the distinct bronchial breathing and the increased vocal fremitus found in adults.

In this respect the pneumonias of children may be classified as follows:

1. Cases with the characteristic signs of pneumonia from the start.
2. Cases with tardy physical signs.
3. Cases without physical signs, the lesion remaining central.

Pneumonia with well marked symptoms needs no further mention. Commonly, before auscultation, at the commencement of the disease no crepitant rale is present, and instead of bronchial respiration only obscure breathing is heard. Two or three days later bronchial breathing settles the diagnosis. Here the lesion is at first central and gradually spreads to the periphery of the lobe. Lastly the lesion may remain central; the little patient evidently suffers from an acute disease and the diagnosis is virtually a guess.

With children, owing to the thin, elastic thoracic walls and to the ease with which breath sounds are propagated from one side of the chest to the other, auscultation is of far less value in diagnosis than percussion. A physician called to a child suffering from respiratory disease, having found dulness in one region of the chest, must first ascertain whether the condition be old or recent, and also whether the exudate be solid or fluid. In this decision the respiratory sounds are of little value, for faint bronchial breathing is common to both pneumonia and pleural effusion. If he can make his little patient speak the vibrations of the voice may assist him, but, as a matter of fact, vocal fremitus can seldom be elicted in a child. When the dulness is in the left side he should search for the apex impulse of the heart; a dislocation of the heart of course points to an effusion, but if the dulness be at the right base, he may reasonably argue that diminished resonance and faint bronchial breathing are common both in hepatization and effusion, and may legitimately resort to the hypodermic syringe for a diagnosis. The same if resistance is greater in a fluid than a solid exudate which together with bulging of the intercostal spaces may offer some slight assistance in pneumonia of the upper lobes; dulness may be localized at the apex, yet if pleurisy be present as a complication the effusion will sink to the base. This obliterates the rational boundaries of the lobes, and the dulness may be continuous from apex to base. Again in pleuro-pneumonia an effusion and consolidation may be present in the same region, the pneumonia and lung may undergo resolution and yet the dulness remain as a most perplexing dilemma to the diagnostician.

The puerile breathing of unhealthy young children simulates bronchial breathing very closely, and bronchial breathing, by itself, is a most deceptive symptom in infants. With dulness on one side we may have bronchial breathing on both, and one should not hastily reach the conclusion that the lesion is bilateral, for in a child breath-sounds are easily conducted.

The point of maximum intensity should be sought, and especial value may be attached to bronchial breathing heard in the axillæ, a region remote from the roots of the lungs. I am persuaded, however, that only by repeated and careful examination of the chest can these difficulties in diagnosis be surmounted.

The course of pneumonia in children is from 7 to 10 days. The disease may end abruptly by crisis, the temperature falling amidst profuse sweating and after general collapse. It has been suggested that these critical sweats may be due to a ptomaine, diaphoretic in its action, a last product of the micro-organism producing the disease.

As has been indicated, pleurisy commonly accompanies the pneumonia of childhood. Pericarditis is also common, the inflammation spreading through analogous serous tissue. Pneumonia in a rachitic child with enfeebled respiratory muscles and deformed thorax is commonly fatal. Secondary pneumonia and double pneumonia also find numerous victims. But ordinarily no acute disease of childhood offers so good a prognosis as pneumonia. The mortality is as low as 2 to 3 per cent., in remarkable contrast to the pneumonia of adults which is often as high as 20 to 30 per cent. I think we may find the explanation of this difference in the structure of the heart. In all cases of pneumonia the issue of the disease depends upon the integrity of the heart, and especially the ability of the right ventricles to force the blood through the inflamed lung. It is well known that children bear a high temperature better than adults and recover more quickly from acute diseases. Thomas believes that the reason that the heart is relatively more powerful in childhood is that the wall of the right ventricle is thicker than in the adult; up to the fourth year the wall of the right ventricle is equal in thickness to the left, while in adult life it is only one third the size. It is also true that in early childhood the muscular force of both ventricles is equal, while in a man the left ventricle has twice the strength of the right. Hence it is concluded that children, by the greater strength of the right heart wall, more easily withstand pneumonia than adults.

Little can be said that is new in regard to treatment. Poultices, as commonly applied, are often a source of more harm than good, and are efficiently replaced by hot fomentations covered with oiled silk. Oxygen is an agent of great value, and should always be used in desperate cases.

In conclusion, it seems to me that the position of a physician called to a young child suffering from an acute disease, is much akin to that of a veterinary surgeon, whose patient is unable to answer questions or to localize its pain. Both practitioners must rely wholly upon their scientific knowledge, and upon their extraordinary care in examination.

PNEUMONIA IN THE AGED. BY JOHN H. PRYOR, M. D.

Pneumonia in the aged presents two well-marked types which have long been recognized and described as pneumonia *in* the aged, and pneumonia *of* the aged. The clinical features of these varieties have been clearly defined by Trousseau and Grisolle. Since their treatises appeared the interesting subject has received trifling mention in medical literature. The most complete description of the pathological changes will be found in Charcot and Loomis' "Diseases of Old Age." In a brief discussion it seems unnecessary to devote much time to a consideration of the sthenic or frank form of pneumonia which sometimes attacks the old but well preserved individual. Somewhat uncommon in advanced life, its clinical history resembles closely the characteristic course displayed by the affection in the adult.

The onset and development are announced by well defined symptoms which afford reliable indications for diagnosis and the treatment does not differ materially. A man at seventy may possess unimpaired powers of resistance and the struggle with disease under such conditions may be as active and pronounced in its manifestations as those which mark the conflict in earlier years of vigor.

After stating the fact that many diseases which afflict the old are prone to assume a typhoid character, *pneumonia in* the aged is only of special interest at this time in showing the striking dissimiliarities which are disclosed by comparison with a distinctive and obscure form of senile affection called pneumonia *of* the aged. As a rule, one is introduced to this important and puzzling subject by very slight reference in a few text-books regarding the high rate of mortality and difficulty in recognizing the extremely common disease. Of recent years it has not attracted the attention it deserves, a fact quickly appreciated when we recall that 80 to 90 per cent. of all deaths after sixty years of age are due to this cause. In presenting a few salient facts for discussion it seems proper to preface with the explanation that information has been drawn from a paper on "Pneumonia of the Aged," by the writer, published in THE MEDICAL PRESS of August, 1887, based upon a study of cases in the Erie County Hospital. Since that time continued observation has strengthened many opinions and perhaps helped to make some statements more decisive.

From a clinical standpoint the study is so broad and perplexing that a lucid description cannot be attempted in a short article. However, a few prominent points of value arrange themselves as follows :

1st. The frequency of the affection and its fatality.

In this climate latent pneumonia is unquestionably the cause of more deaths in the aged than all other diseases combined. Recent authorities agree that the mortality rate in those over sixty years is about 80 per cent., and it steadily increases with advancing years. Inability to diagnose the disease causes it to be often overlooked, and many deaths ascribed to other causes will be found at the autopsy to have resulted from senile pneumonia.

2nd. Elements of causation.

These relate principally to senile changes in the blood vessels, lungs, and chest wall. There is a diminution and apathy of function, and loss of sensibility tending to subdue resistance. Bronchial catarrh of a lower grade exists in a majority of cases. The circulatory disturbances resulting from weak heart, arterial changes and vasomotor disturbances accompanied by other complications, such as embolism or tendency of vesicular structures to collapse, are potent factors in the causation. Adding those dyscracias and injuries, such as syphilis and fractured hip-joint, to which pneumonia is apt to play a secondary and closing part, we have touched upon the intrinsic influences sufficiently to show that in old age there is a striking predisposition to the disease. The respiratory mucous membrane is particularly exposed to influences of a changeable and trying nature, to which the aged easily succumb. The vast majority of all cases occur between November and May. A northeast wind in the spring months is almost sure to develop a number of cases within a few hours. As to the lodgement of food in the bronchi, as mentioned by Traube, I have never seen such a case and believe it to be an uncommon cause, except in cases of mental debility or dementia. The septic origin of this particular form of pneumonia has not been investigated, to my knowledge.

3rd. Morbid changes.

The morbid changes differ from those seen in the adult in various ways. The upper lobe is more apt to be affected and the disease to extend downward. In the stage of congestion the affected portion crepitates less and the lung does not sink in water. Owing to rarefaction it does not sink to the bottom of the vessel even when hepatized. The exudate is more fluid and it is sometimes difficult to decide whether the lung is simply congested or pneumonia in the first stage be present. If a section of the tissue be placed under a microscope a viscid fluid will be seen exuding from the vesicles, which coagulates on the addition of alcohol into an amorphous granular substance containing red blood globules. Œdema of the lungs is frequently present. The pneumonia is more apt to be double and the left lung is affected nearly if not quite as often as the right.

4th. Diagnosis.

The clinical features of senile pneumonia are of such varied and obscure nature that the utmost care and diligence are requisite for their detection. There are cases in which, to the ordinary observer, the patient betrays not the slightest sign of his condition. In others there are symptoms of grave disease, but of such indefinite character as to mislead rather than guide the physician. The premonitory symptoms are never sufficiently distinctive to determine whether they are due to advancing disease or to those ill-defined and transient ailments peculiar to old age. The invasion of the disease is marked by a train of symptoms not less vague. Those upon which we may place the most reliance are chills, malaise, and apathy, anorexia, malar flush, slight cough and changed facial expression. The temperature usually rises to 102° to 105° F. in the rectum, the pulse is more rapid and apt to become irregular, the respirations rarely pass 30 per minute. I have noticed a peculiar form of respiration which I have come to regard as somewhat diagnostic. The breathing is short, shallow, and slightly rapid, one shoulder is raised, the head thrown back and the whole act performed with apparent effort. The cough may be slight or wanting. In the insane and those mentally weak, both cough and expectoration are absent. Curiously enough the cough and dyspnœa of a chronic bronchitis, or asthma, frequently subside on the supervention of a pneumonic attack. The expectoration may be colorless like that of œdema, or of a prune juice or chocolate color, which is always an unfavorable prognostic. I have never seen a purulent expectoration during any stage of the disease. The patient is apt to be depressed, with stupor merging into coma, or deliriously active. In most cases we have but to remember that the disease attacks only the old and infirm, and that the symptoms are apt to be typhoid in character. Grisolle states "that we must base our opinions first, on the extreme frequency of pneumonia in old age; secondly, that of all the phlegmasiæ of advanced life, pneumonia is the one that is oftenest latent; and thirdly, that of all acute diseases, pneumonia produces the highest range of temperature and the greatest prostration." A knowledge of the presence of this disease will depend mostly upon frequent examinations of the patient, and careful attention to slight symptoms. It is a wise rule to exclude pneumonia first. The diseases most apt to simulate pneumonia, are hypostatic congestions, simple congestions, œdema, capillary bronchitis and pleurisy with or without effusion. At times the points of differential diagnosis are not clearly delineated, and analysis is necessarily slow.

PHYSICAL SIGNS.

The physical signs are always unreliable and subject to wide variations because of the changes in the lungs and chest walls. Certain modifications of the principal signs are present in all old people, and often prove misleading. Practice alone can make one familiar with these changes. The cardinal rule of comparison loses its usual significance. The breathing becomes slightly altered and approaches a tubular character. When the exudate has filled a portion of the lung to a considerable extent, dulness is increased somewhat, but is a sign of relative value. If marked dulness be elicited, fluid in the pleural cavity may be suspected. This condition often passes unrecognized. Unless the dulness be very plain, it can be brought out only by light percussion. Deep percussion gives the resonance of the whole chest. When the upper lobe is affected, the dulness is rendered less distinct by the rigidity of the sternum and chest wall, and the retraction of the lung away from the ribs. Later on tubular breathing of a distinctive character may appear, and is absolutely diagnostic. It is even more intense than that heard in the adult, and has a metallic quality with prolonged expiratory sound of high pitch. There may be associated the bronchial souffle, or the veiled puff of Laeunec. Gurgling and subcrepitant rales persist, and the broncophony is somewhat changed by the weak, quavering voice of the aged.

To my ear it is not ægophoric as stated by some authorities.

PROGNOSIS AND TREATMENT.

The prognosis is almost invariably fatal. I have never seen but two cases recover, and in those there were no complications. Age, general condition and complications, such as diseases of the heart, arteries, and kidneys, are the factors of greatest importance. Œdema or pleurisy with effusion is an unfavorable sign. Pneumonia of the upper lobes and double pneumonia are almost certainly fatal. Those who survive the seventh day recover. Recovery is generally marked by a somewhat lengthened crisis, and a critical diarrhœa is more common than a critical sweat. The symptoms of approaching death are those due to imperfect circulation, or oxidation. The breathing becomes shallow and sighing, gasping or puffing, and sometimes orthœnœa with dilatation of the alæ nasi appears. Death results from heart failure, which may result from shock-paralysis or slowly from exhaustion. Consequently the diagnosis, as governed by treatment, depends almost entirely on the dynamic action of the heart. Obviously we have to deal with a feeble heart which is endeavoring to perform increased work under discouraging conditions, excepting that its undue activity is caused by sepsis, vasomotor perversion, a solidified portion of lung and an elevated temperature, and that it is usually greatly hindered by arterial and other changes, the dangers and indications for treatment are apparent. Nourishment and stimulation should be discreetly crowded from the first. The aged cannot break up alcohol as readily as the adult, and if not given judiciously it may cause depression from narcosis. Small doses frequently repeated, continued stimulation and avoid the sedation following large doses which is never beneficent. Among the cardiac stimulants, tr. strophanthus and tr. glonoin are preferable to all others. A continuously high temperature involves greater tissue waste and depression in the old and debilitated. Cold sponging, cautiously employed, is safer than the use of antipyretics. Antipyrine acts well in some cases and badly in others. Any successful measures must be begun early. Symptomatic treatment is often beset with difficulties because of the paucity and masked character of the subjective symptoms. The senses are benumbed and the strength subdued so that discomfort is trifling and the complaint rarely heard.

> "——Then the ills of age, its pains, its cares,
> The drooping spirit for its fate prepares."

IS ACUTE LOBAR PNEUMONIA AN INFECTIOUS DISEASE? BY W. H. BERGTOLD, M. D.

If different authors and writers, from the earliest to those of the present day, are consulted relative to the question whether this disease is a distinct one, or merely an inflammation involving the lung and giving rise to pyrexia, etc., that is, whether it is to be classed with the group embracing typhoid fever, measles, small pox, diphtheria, or with those which we know are due to some accidental cause, as a gastritis, an acute cystitis, etc.—I repeat, if we consult such writers we shall find every shade of opinion, leaning to one or to the other side, with, however, this notable fact, that as we approach our present decade the belief becomes more and more prominent that acute lobar pneumonia is a distinct, specific disease, and as such is to be ranked with any of the exanthemata. Whenever the word pneumonia is used in this discussion, reference is made to that form known to the Germans as "croupous pneumonia," and to us as acute, lobar, fibrinous, or croupous pneumonia.

In order to discuss the question whether it is an infectious disease, we must first of all decide whether it is a disease *sui generis* or a local inflammation. I believe that the vast majority of the writers of reasonable note are agreed that it is a distinct disease. I assume, therefore, that this is the truth. If we mean to say that pneumonia, in order to be called infectious, must be a disease which is due to a specific living contagion which under well-known and ascertained conditions will always give rise to the same results, to wit, the disease, and must also be a disease which is known to have occurred in well-marked and undoubted epidemics, then, I think, it can be shown that croupous pneumonia is an infectious malady. If this be true, then we must rank it with typhoid, tuberculosis, etc., differing from the others by degrees in the intensity of its infectiousness, as do all the members of this group, one from the other. Of the different ideas regarding pneumonia's infectiousness, Roberts says, in describing a series of cases, that "Epidemic pneumonia has been described." A writer in the *British Medical Journal* of 1883 says: "The pneumonia was of the ordinary croupous variety, of a decidedly infectious type, and at times it appeared to be contagious." Germain See writes: "Despite the persistency of many modern pathologists in regarding fibrinous pneumonia as a simple inflammation of the lungs, epidemics of pneumonia have long been mentioned." Jurgensen believes that it properly belongs to the group of infectious diseases, and is due to a specific exciting cause. Strumpell states that: "The majority of pathologists have now become convinced, from a series of clinical facts and observations, that the cause of pneumonia is to be sought in an infectious agent, which enters the lung, and there gives rise to the development of the inflammatory process. All of the pathological appearances coincide with this conception of the disease, and it is a noteworthy fact in favor of our estimation of pneumonia as an acute infectious disease that it may be endemic." Finally Ziegler declares without any reservations whatever that "Croupous pneumonia is an inflammation of one or more lobes of the lungs, and has the characteristics of a certain specific infectious disease." We are prone, I think, when a disease is said to be infectious to immediately compare it with some other one that is throughly characteristic of this quality, and if the disease under comparison does not come up to such a standard we forthwith think, if we don't say so, that the property of infectiousness does not belong to the disease. This is a wrong inference entirely, and I draw attention to it that it may serve as a reminder, that no two of the undoubted infectious diseases are alike in their manifestations of infectiousness. While no one would gainsay that typhoid fever is an infectious disease, yet how seldom are those nursing typhoid patients stricken by it, and, on the other hand, we all know full well with what comparative certainty measles or scarlet fever strikes those who have not had it, and are exposed. We shall see, I hope, later on that it is not at all essential for every one exposed to subsequently develop pneumonia, and if we grasp even only a part of the latest and most modern contributions regarding its etiology we shall see that the great immunity of those exposed is just what we might expect from a study of the peculiarities of the way of the transmission of pneumonia, and that the occurrence of so many isolated cases does not militate at all against an infectious view of the nature of the trouble.

There are two sets of observations which lead me to assume that croupous pneumonia is infectious: 1st. The results of bacteriological researches. 2nd. The occurrence past and present of many most marked and characteristic epidemics, with the records, also, of many isolated cases tending to establish for pneumonia under peculiar conditions a contagious quality.

Klebs was the first to describe a micrococcus found with some cases of pneumonia, and now known under the name of "Friedlander's Pneumonococcus." Friedlander, who investigated this peculiar coccus very extensively, describes its presence in the pulmonary tissues, the alveolar exudate, the sputum, the blood, and the pleuritic exudate. They are spheroidal cocci, found single, double, or in small chains, and each one is surrounded by a capsule which takes the usual stains very faintly. Various workers have isolated and obtained them in pure culture, which when suspended in sterilized distilled water, and injected into different annimals produce varying results. Every one of thirty-two mice succumbed with characteristic pneumonic lesions —found post-mortem—while the results in dogs and guinea-pigs were uncertain, and in rabbits no infection occurred at all. It was then observed that there was a difference in the size of the bacteria when isolated from different animals inoculated with apparently similar pure cultures.

There is, however, another coccus which is quite like the above, which has been studied by Sternberg and others, and to which he gave the name Micrococcus Pasteuri. The Germans call it "Frenkel's pneumonia coccus," and "Bacillus septicus sputidigenus."

In a recent paper before the New York State Medical Society, Dr. Sternberg said: "For some time after the publication of Friedlander's paper all observations made with reference to the presence of oval cocci, or incapsulated cocci in the fibrinous exudate of pneumonia were supposed to confirm his discovery. But we now know that there is another oval coccus which is far more frequently present in the exudate of acute pneumonia, which also presents the appearance of being surrounded by a transparent capsule—less pronounced, however, than that of Friedlander's bacillus—but which is entirely distinct from that of Friedlander, and is probably the true pneumonococcus."

Out of 129 cases of croupous pneumonia Weichselbaum found the M. Pasteuri 94 times, and the bacillus of Friedlander in but three cases.

This micrococcus of Sternberg is pathogenic when injected into rabbits and mice; if a sufficiently large quantity of the pure culture be injected into a rabbit the animal dies of septicæmia before any characteristic pneumonic changes occur in the lungs. To quote See again: "The rather brief description of the lesions obtained by Friedlander in the mice inoculated by him leaves some doubt in the mind; for the presence of foci of induration in congested lungs is not sufficient to characterize fibrinous pneumonia. But the lungs of rabbits presented by Salamon to the Anatomical Society in support of his communication leave no room for discussion. As he observed, it was not at all a question of foci of congestion or of broncho-pneumonia, such as one observes habitually in rabbits which die of septicæmia, but a veritable lobar fibrinous pneumonia, with pleurisy and pericarditis of the same nature. The naked eye examination, as well as the microscopic, showed no difference in the lesions produced in the rabbit and the pneumonia of man." Sternberg's belief that the M. Pasteuriis the cause of croupous pneumonia is entertained also by.

Frankel, Weichselbaum, Netter, Salamon, Gamaleia, and many others.

The true pneumonococcus is a pathogenic plant, and not a saprophyte, as is Friedlander's bacillus, and while the latter can perpetuate its species without the intervention of a warm blooded animal, the former cannot. Hence, as we would expect, this coccus is always found about some warm blooded animal, and most frequently in the mouth of man, healthy or otherwise. In this situation it finds the necessary temperature, moisture, and subsistance essential for its growth and multiplication. It sometimes remains constantly present in the saliva of a given individual for a long time, and then disappears to return in a few days or to be absent for a long time. Why doesn't this bacterium, if the cause of fibrinous pneumonia, manifest its peculiar inflammatory effects more often? It seems to me that this is best explained by the hypothesis that so long as the lungs maintain their normal tissue resistance the micrococcus fails to be potent, because the leucocytes are able to cope with, and destroy it.

If this same tissue resistance be sufficiently lowered, as by a vasomotor paralysis of a pulmonary lobe through exposure to cold, by an injury to the lung, by the depression of some severe disease as typhoid fever, or from the effects of breathing for some time the foul and vitiated air of a densely crowded prison or barrack, we find that a true croupous pneumonia frequently supervenes because the needful contagion is present in the mouth. We know that it is not an unusual thing to have one of the above mentioned tissue-depressant is present and working its ill effects, without a pneumonia ensuing.

This fact instead of weighing against the assumed etiological position of M. Pasteuri, makes it the more tenable, for we have already seen that the coccus is often absent from a given person's mouth. It does not require much credulity to believe that the requisite germs were absent when the depressant was in force. In looking over the literature of this aspect of lobar pneumonia, I not only found that epidemics of pneumonia were not uncommon, but that they are recorded in such abundance that See was led to classify them into four divisions. Those of prisons and barracks are the most frequent, and by far the most characteristic.

This unquestionable epidemic tendency of pneumonia is an attribute which alone ought to, and, to me, does stamp it as a true infectious disease.

While we can never hope to stamp out true croupous pneumonia, which, according to Jurgensen, causes 6 per cent. of all the deaths throughout the world, by disinfecting patients' mouths and sputa, because healthy individuals, whose saliva contains cocci, will probably go on expectorating and thus disseminating them, yet I believe it is just as much the duty of a physician to order the expectoration and mouth of a pneumonic patient disinfected, as it is in a case of phthisis or diphtheria.

To recapitulate; I believe from the evidence advanced by various observers and experimenters that:

First. Croupous pneumonia is a specific infectious disease.

Second. That it is caused by an oval incapsulated micrococcus, the M. Pasteuri, and which has its principal habit in the mouths of both healthy and diseased people.

Third. That it is not infectious in the sense termed contagious.

Fourth. That it develops only when the pulmonary tissue-resistance is so lowered that the cocci are able to gain a foothold.

Fifth. That traumatism, exposure to cold, the exhaustion of other diseases, and the respiration of vitiated air of crowded places, as prisons etc., are most potent causes of such lowering of the pulmonary tissue resistance.

FORMS OF ACUTE LOBAR PNEUMONIA. BY C. R. JEWETT, M. D.

With reference to amount of lung involved and its location, we have single and double pneumonia. When single the right lower lobe is more frequently attacked, next in frequency the left lower lobe, next the right upper lobe, the middle lobe being least frequently the seat of this disease.

Double pneumonia occurs in about 12 to 15 per cent. of cases.

Lobar pneumonia may be a primary or secondary disease. When secondary it is most frequently seen in typhus and typhoid fever, measles, dysentery, diphtheria, erysipelas, chronic nervous diseases, chronic alcoholism, uræmia (acute and chronic), pyæmia, septicæmia, articular rheumatism, epidemic spinal meningitis.

There is an epidemic lobar pneumonia, which is also called pythogenic and is due to some miasmatic or zymotic influence.

There are often terms which are applied to forms of lobar pneumonia depending upon the physical condition of the subject attacked, and the general character of the disease itself. Thus we have an abortive, sthenic, asthenic, malignant, typhoid and icteric.

Some claim that there is a contagious form of lobar pneumonia, that it is due to a specific microbe, a diplococcus. If this be true, then undoubtedly all forms are contagious in the same sense; and it may be classed with typhoid fever as a miasmatic contagious disease.

There is a pneumonia which is called irregular, occurring where there are many symptoms pointing to different organs. This form is often difficult to diagnose, and perhaps is made out quite as often at the *post-mortem* as before.

Then there is Dr. Loomis' sewer-gas lobar pneumonia, of New York City, which he claims is due to sepsis, over crowding, bad ventilation, and general anti-hygienic surroundings.

MORTALITY RATE AND CAUSES OF DEATH. BY STEPHEN Y. HOWELL, M.D.

It requires no special argumentative effort to convince the members of this society that the statistican who would present accurate and reliable information concerning the mortality of lobar or croupous pneumonia is attempting a very difficult, if not an impossible task. The data at his disposal represent in most instances the contributions of a number of medical men (or women), whose views in the great majority of cases concerning the cause of death have not been confirmed by autopsies ; and what optimist is prepared to champion the right and title of even the modern profession to the dogma of diagnostic infallibility? How many deaths, think you, which have been ascribed to the agency of croupous pneumonia have in reality been due to the supervention of some complicating malady? How many children and aged people who have actually succumbed to pneumonia are enrolled as the victims of "fits," "worms," "teething," "semile decay," "old age," etc? And, finally, should the cause of death have been rightly located, how are we to feel assured that the pneumonitis was lobar in character and not catarrhal or interstitial,—that it was due to the agency of the pneumonic microbe rather than to others of the pathogenic schizomycetes?

In view, then, of these sources of error, and of others which readily suggest themselves, it would be highly presumptuous for me to claim that the figures which follow are specially reliable; indeed, they chiefly serve to illustrate the pressing need of more extensive and systematic work at the post-mortem table.

Glaring as are the defects of mortality statistics, however, they serve a very useful end, and from their study we are enabled to glean many a fact of prime importance to the race. Thus it becomes very apparent after a merely cursory review of post mortem records that idiopathic or primary croupous inflammation of the lungs occupies a very prominent place among the potentially fatal diseases; some 6.6 per centum of all deaths being ascribable to this cause, according to Juergensen,—that is, about 12.7 per cent., of the total mortality due to internal diseases. In virulence, indeed, it is surpassed only by that scourge of humanity, phthisis. The significance of these statements will be more thoroughly appreciated when we learn that in London 323 out of every 100,000 of the population die annually of pneumonia, while Paris and Berlin lose 382 and 296 respectively.

Hospital mortality-reports fail to give a correct estimate of the part played by lobar pneumonia; since autopsies are not always held to determine definitely the nature of the pulmonary lesion and the presence or absence of complications. However, I would state, that in the Vienna General Hospital (1858–1870) out of 7942 cases reported as pneumonia, 1944 ended fatally, that is 24.5 per cent. In the Seraphim–Lazareth of Stockholm (1840–1855) 281 out of 2616 cases perished, or 10.7 per cent.; the Greifswald Polyclinic reports 941 cases and 102 deaths, that is 12.1 per centum; while, finally, there occurred 213 fatal cases of pneumonia out of a total number of 922 in the hospital at Basle, Switzerland, during the years 1839–1871, a mortality of 23.1 per centum.

A careful examination of the reports issued by the Buffalo Department of Health, beginning January 1st, 1882 and extending down to the present month (May, 1889), reveals a number of interesting facts, and the result is appended in tabular form. In this table the total number of deaths reported for each month and the fatal cases of pneumonia occurring during the same period are compared, the victims of violence (rail-road accidents, drowning and other casualties, suicide, homicide, and judicial hanging) being alone excluded from the former list. Not only will the marked prevalence of the disease during the six months of winter and spring impress the reader, but it will seem remarkable that the rapid increase in the population has affected in so slight a degree the annual percentage.

TABLE COMPARING THE MONTHLY DEATHS FROM PNEUMONIA AND THOSE FROM ALL OTHER CAUSES, SAVE VIOLENCE. COMPILED FROM THE VITAL STATISTICS OF BUFFALO.

	1882.		1883.		1884.		1885.		1886.		1887.		1888.		1889.	
	Pneumonia	Total	Pneumonia	Total	Pneumonia	Total	Pneumonia	Total	Pneumonia	Total	Pneumonia	Total	Pneumonia	Total	Pneumonia	Total
January	20	278	19	249	27	201	39	346	32	320	31	363	30	331	34	253
February	35	319	17	224	22	256	37	281	13	254	37	293	50	365	28	306
March	56	301	27	366	34	334	34	271	36	276	38	261	57	449	27	361
April	69	400	28	231	16	179	18	254	27	263	49	411	50	366	89	920
May	27	346	38	287	28	316	33	360	21	289	24	282	55	384		
June	11	260	21	232	16	237	21	260	15	217	17	271	25	371		
July	12	341	7	264	13	302	9	263	16	451	14	688	16	417		
August	11	411	6	379	8	554	18	556	8	382	8	483	13	555		
September	15	465	8	325	11	404	23	330	14	356	17	370	23	534		
October	11	295	15	253	19	368	15	334	20	377	28	425	24	323		
November	9	242	10	197	24	335	21	256	19	282	25	275	22	261		
December	22	279	28	286	36	257	25	261	15	281	31	375	34	343		
Total	298	3937	224	3293	254	3743	293	3772	246	3748	319	4497	399	4699		
Per Centum	7.6		6.8		6.8		7.8		6.6		7.1		8.5		9.7	

CAUSES OF DEATH.

In general terms it may be said, that while idiopathic croupous pneumonia is a disease of grave import, it is comparatively seldom fatal in the case of individuals previously vigorous and healthy. When, however, the amount of lung-tissue involved is very extensive; when the patient's powers of resistance have been enfeebled by excessive indulgence in food and drink, or by the ravages of age: and finally, when secondary, or complicating disorders combine with the pulmonary disease to undermine the individual's vitality, the mortality becomes very great.

The influence of season, meteorological conditions, sex, and age upon the mortality of this disease will not be touched upon, since they pertain more closely to its etiology.

The *heart* is the organ upon which the great burden is sooner or later imposed in lobar pneumonia; and upon the failure to prevent or relieve the exhaustion of this muscular pump hinges the fatal issue.

But what are the potent factors in effecting this dreaded cardiac insufficiency? Simply the disturbance of the pulmonary functions and the pyrexia; which are so constantly associated with this disease. The effects of these two conditions may be briefly formulated, as follows:

1. The pneumonic exudate increases the labor imposed upon the right ventricle by augumenting the intra-pulmonary resistance to the circulation.

2. The aid afforded by the respiratory muscles in promoting the circulation of the blood through the lung is partially annulled by the consolidation of the latter organ.

3. The available surface for the physiological interchange of substances between the blood and the air is diminished; greater labor devolves upon the heart and respiratory muscles in order to maintain the integrity of the blood.

4. The fever not only increases the work to be performed by the heart, but likewise inflicts a direct injury upon the cardiac muscle whereby its functional efficiency is more or less impaired.

The primary effect of the beginning heart-failure, which first declares itself in the overworked right ventricle, is passive pulmonary hyperaemia, resulting in more or less œdema.

Engorgement of the cerebral sinuses and veins from the same cause may occasionally cause coma and thus contribute to a fatal result. Should death ensue, the right heart is found filled with a coagulum which extends into the pulmonary artery; while the left ventricle is empty.

In an article by Liebermeister, based upon a series of cases of acute lobar pneumonia and reported in the *Brit. Med. Jour.*, Dec. 29, 1888, the cause of death is explained in like manner, viz:

The heart, degenerated by the pyrexia and functionally weakened, is forced to contend against an increased resistance, due to the compression of the blood-vessels by the pulmonary infiltrate. Under these conditions the right heart gradually fails, oedema ensues in the non-infiltrated portions of the lung, and death finally results.

THE BEST TREATMENT OF ACUTE LOBAR PNEUMONIA. BY DR. C. C. FREDERICK.

Acute lobar pneumonia is a self-limited disease. The past history of its treatment includes many plans to abort it or to shorten its course. Venesection, salivation by mercury, depression by tartar emetic, veratrum viridi, and aconite have all signally failed. It is questionable whether more lives have not been lost by these active measures than would have been by expectant treatment.

Uncomplicated pneumonia occurring in certain conditions and periods of life usually recovers spontaneously. When complicated or occurring in the very young, old or feeble, it is almost necessarily fatal. No routine plan of treatment is applicable to all cases, not even to all plain uncomplicated cases. The lung itself needs no treatment. Hence jacket poultices are not necessary. They are positively uncomfortable and annoying to the patient. The wrapper may be lined by one thickness of cotton batting or lamb's wool, and the chest rubbed by some stimulating embrocation. This is all that is necessary as a local measure, serving to keep the skin active and warm, at the same time being light and comfortable. The patient should be placed in the best hygienic surroundings and given an abundance of pure, cool air. The recumbent posture should be strictly maintained till convalescence.

The diet must be fluid or semi-solid. Eggs, milk and concentrated meat extracts and broths are the most serviceable. Milk is the staple food for the sick. It ought to be taken in small quantities, hot, at short intervals, rather than in large quantities at longer intervals. The monotony of a milk diet may be varied by giving kumyss which is often a refreshing change. In cases of feeble digestion, the various preparations of milk with pepsin or ext. pancreatis will obviate the difficulty and maintain good nutrition. The pain of the first few days may be controlled by opiates. In all severe cases of croupous pneumonia there are two great sources of danger—heart failure, and high temperature—which helps to produce heart failure. The indications for treatment therefore are principally to sustain the heart and to reduce the fever if high.

The cardiac stimulant, par excellence, in pneumonia is alcohol. It requires careful study of the case, and considerable discretion and judgment to decide the best time to begin stimulants and the quantity to give. A feeble, frequent, intermittent or irregular pulse is an indication of heart failure. The effect of alcohol upon the pulse together with the general appearance of the patient are the criteria by which to determine the amount required. It is usually better to begin its use in small quantities. The plan of some to begin stimulation early in every case on general principles, and to saturate the patient, cannot be too strongly deprecated.

In combination with alcohol it seems to me that opium in small doses is of use in quieting the delirium and jactitation during the crisis. Opium itself in small doses is stimulating and seems to me not to be contra-indicated. Strychnia also may be administered to assist the alcohol.

Carbonate of ammonia seems of doubtful efficiency. To obtain much stimulation from it, large doses are required, and large doses are liable to interfere with stimulation by the nausea and vomiting which it produces.

Pneumonia may be severe without a high temperature, and the temperature may be high while the case is not serious. These facts accord with the experience of all physicians.

The German plan of antipyresis by cold water baths is not practiced in America. But the judicious use of cool water by the sponge bath is of use in adding to the comfort of the patient, and at the same time helping to reduce temperature however to a limited degree.

Except in pneumonia complicated with rheumatism or malaria, salicylate of sodium and quinine have not the place in its therapeusis that were accorded them a few years since. Antifebrin and antipyrin have come to claim the antithermic honors. In most cases of high temperature one or the other of these drugs can be used with benefit. If cautiously administered, at the same time using alcohol, they are not apt to be followed by much depression. I prefer antifebrin in most cases in 3 to 5 gr. doses for adults, given every 4 to 6 hours. I believe with Dr. Stockton that, "An antipyretic drug applicable to every case will never be discovered."

The selection of the antipyretic must depend upon the study of the individual case and it must be administered with the same judgment and discrimination that the stimulation of a flagging heart demands.

Inhalations of oxygen for the relief of dyspnœa and cyanosis will add to the patient's comfort and may serve to prolong life and bridge over the crisis. Let me say in conclusion that the result of the attempts at the antiseptic treatment of pneumonia so far, is this: the antiseptic era of medicine has not been followed by startling results.

The annual meeting of The Central New York Medical Association was held May 13th, at Syracuse. A large attendance was noted and papers of interest were read, among others, by Drs. Weigel and Roe, of Rochester; Drs. Van de Warker, Van Duyn and Didama, of Syracuse; Dr. Wise, of Ovid; Dr. Roberts, of New York; and Dr. Daly, of Pittsburgh.

DIED.—Sunday, May 12th, 1889, at his residence in this city, Dr. Tobie, at the age of 58. His death was as sudden as it was unexpected, being the result of an apoplectic stroke.

Dr. Tobie was one of the oldest and most highly esteemed members of the local profession, and the unanimous expressions of regret at his loss which are heard from all his old confreres show him to have been possessed of the noblest traits of character. Honest and earnest, faithful and industrious, he made friends everywhere and had no enemies. He had an immense practice, and his untimely death was doubtless due to the fact that he never spared himself. He did an immense amount of work of the most exacting character.

A scientific journal has recently called attention to the influence of color on the sick and insane; experiments in Italy have shown that mental and physical suffering can be relieved, if not cured, by the use of certain tones. At a hospital in Alexandria special rooms are assigned to insane patients. The Red Room has been found of great value in cases of the commonest forms of dementia, such as melancholia, accompanied by refusal to take food.

The printing department connected with this magazine is well equipped for all classes of work from a book to a small card. Physicians in need of printing should give us a trial order.

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IMPORTANT ANNOUNCEMENT.

VALEDICTORY.

Nearly four years ago, in the first number of THE MEDICAL PRESS, we stated fully and unequivocally the reasons which led to its establishment. We do not wish to repeat them now in detail. We deemed then that some explanation was due to the profession at large for the violation of the generally accepted fact that there are too many medical journals in this country. Having always thoroughly believed this to be the case, we yet offered for consideration a justification of this course which was, we are sure, perfectly acceptable.

We have now to make another announcement which we trust will meet with equal favor. The causes which operated at that time to create an urgent demand for a new journal having ceased to exist, it is proposed to merge this journal into its older and equally well known contemporary *The Buffalo Medical and Surgical Journal.*

As we view this consolidation, it is no sense a confession of anything but a desire to promote the grand object of fraternity and professional harmony. Under its new management the gentlemen who conduct the last named journal have given every pledge of their intention to conduct it as a purely scientific and non-partisan journal, devoted in large measure to an exposition of what Western New York can do. This being the case, it now limits itself to the same field which THE MEDICAL PRESS has always occupied, and no good cause can be ascribed why two rivals should contest a field that can be better filled by one after an amicable arrangement.

Aside from this, an ample reason for instituting a change of some kind is found in the fact that the present editor has continued his work, thus far in the present year, under protest. Such an amount of professional and other work has forced itself upon his attention that an early change in editorship would have been imperative under any circumstances.

This June number will, therefore, under the new arrangement be the last issue to appear under the old title and regime. The last at least until circumstances, unforseen and undesired, shall lead to its reestablishment for some cause comparable only with those which gave it birth. This agreement between the journals has been ratified by our stockholders, is satisfactory to our publishers, has been deemed desirable by those most interested in the conduct of each, and we trust will be equally acceptable to our subscribers and readers. To all the subscribers of THE PRESS the *Journal* will be sent during the unexpired portion of their term of subscription.

To our editorial colleagues we bid a fraternal adieu. Their assistance has been so valuable and so kind that our only feeling of pain in laying down the editorial pen is that the pleasant relations of the past are now to be severed. It is pleasant, however, to feel that our other associations are to be in no wise disturbed by this change.

To our readers the editor would say that as in the past he has endeavored to win and deserve their esteem by a straightforward and unevasive policy in conducting this journal along the lines laid down at first, so now he trusts that they will in his present retirement from active journalism see the most outspoken expression which he could make of a desire to harmonize, consolidate and elevate professional interests in this locality.

DR. PRUDDEN'S RESEARCHES ON THE ETIOLOGY OF DIPHTHERIA.

In recent numbers of the *American Journal of the Medical Sciences* there have appeared from the pen of Dr. Prudden, of New York, a series of papers detailing the results of his investigations concerning the etiology of diphtheria. As it has long been known that Dr. Prudden was carefully studying this subject we have awaited the publication of his results with eager interest, and now that they have appeared, with beautiful illustrations, and because of his well known accuracy of investigation, we feel that he has made a contribution to this subject whose importance is not outweighed by the labors of any other investigator.

He calls attention first to the fact that the presence or absence of a false membrane, while usually indicative, is not always absolutely diagnostic of diphtheria; that cases of grave systemic disturbances have been noted when no false membrane was to be discovered; and that, on the other hand, the membrane was sometimes found in excess when there was little or no systemic disturbance. Evidently diphtheria is an acute infectious disease, and if so the great advances in our knowledge of other diseases of this class would justify the conjecture that it is caused by bacteria of one or more particular species. Should this species be ultimately discovered in the local lesions most of the difficulties of definition which now beset us would be removed; then we should know what causes diphtheria and what it truly is, and how to define it. In the search for the etiological factor various bacteria have been observed, but we have long since learned that morphological examination does not suffice for determination of bacterial species. They must be cultivated in pure form and experimented with under like conditions. When animals have been inoculated with a false membrane various phenomena have resulted; but in the experimental animal neither false membrane, nor septicæmia, nor local inflammation, nor even a simultaneous occurrence of all of these, necessarily constitute diphtheria. In the endeavor to avoid the numerous possible sources of error, Dr. Prudden set himself a very severe test, which was to ascertain first, by modern culture methods, what living micro-organisms were generally present at or about the seat of the lesion, or in the internal organs, with sufficient frequency to justify the assertion that they might stand in etiological relationship to the disease, and then to propagate these in pure cultures and study their life history. Second, to learn by morphological examination of sections of the hardened and stained tissues what were the situation, distribution and comparative numbers of the bacteria present. Third, to ascertain the effects upon animals of the inoculation of isolated species. In all cases plate cultures were made, and, so far as we know, Dr. Prudden is the only one of the various investigators of this subject who has taken this extra precaution.

Twenty-four cases of diphtheria were carefully studied after this fashion, and in twenty-one a streptococcus form was met with in the false membrane. This was present usually in enormous numbers, and upon examination was found frequently in the kidney, spleen and other organs. It was not only the predominating form, but was the only form which appeared to penetrate the underlying tissues. The second most common form was the ordinary staphylococcus which however appeared not to bear any relationship to the pseudo-membrane. The bacillus of Loeffler was not found in any of the cases. He follows this general statement with a careful biological description of the particular streptococcus he so often met with, and supplements this with a careful resume of experiments upon animals. His conclusions from the latter must have a large interest. He has found a special form of bacterium which was almost invariably present, and in such a way as to justify the view that it sustains an etiological relationship to the disease. It has been carefully examined and its characteristics recognized, and inoculations of pure cultures of this organism have been made upon animals. He has found that the suspected bacteria were markedly pathogenic, but he was unable to induce a disease which could fairly be recorded as diphtheria. In explanation of the apparent failure to reproduce the disease, it should be stated that it is very doubtful whether any of our domestic animals are ever subject to diphtheria as we know it in man.

There is a certain animal's disease which has been called diphtheria, but it is not of the same character as diphtheria in man, and the species of bacteria which are found are entirely different. Of the many thousands of attempts made to implant diphtheria in animals there does not appear to have been a single instance in which it has succeeded. He does not state definitely that diphtheria cannot be produced artificially in animals; he simply takes the ground that up to the present it has not been so produced.

His final conclusion in this relation is as follows : "On the whole, considering the insusceptibility of animals to diphtheria as we know it in man, the result of all these experiments, taken together, certainly justifies us in the assumption that, in a certain class of cases at least, diphtheria is caused by a streptococcus having the characteristics already set forth." Having this strong pathological basis for his belief, he went further and experimented with the germ, or with the membrane containing it, in various ways. He found that dried bits of membrane even after fifty-four days would, under favorable conditions, develop quantities of a living organism. He also experimented by freezing them and exposed them to a temperature of 14° F. for seventeen hours without notably affecting their vitality. The effects of various germicides were also noted. Moist hot vapor he found much more efficient than dry heat in destroying the germ, but in either form it was found entirely inefficient for the purpose of practical disinfection. Carbolic acid in order to be of practical efficiency must be used in at least two per cent. solutions, and its action must be prolonged. Creolin was found to be a little more efficient than carbolic acid. Bichloride of mercury was found reasonably efficient.

His remarks concerning prophylaxis and especially those relating to house disinfection are of no small importance, but are too long to be copied here at length. As stated in the beginning we regard Dr. Prudden's contribution as one of the greatest interest and value, and as reflecting the greatest credit upon himself and his methods of work.

DEVELOPMENT OF MAMMARY FUNCTIONS IN THE SKIN OF LYING-IN-WOMEN.

In Vol. LXIX. of the *Medico-Chirurgical Transactions* is a very interesting paper with the above title, by Mr. Champneys of St.

George's Hospital. The subject of numerical abnormalities of the breasts and nipples has in times past received considerable attention. These supernumerary structures are in the great majority of cases situated below the normal mammæ and a little nearer the middle line. When they are above the mammæ they are always more external than the normal structures. But the abnormality alluded to above is not the only one in this connection which interests the biologist. It has been known to pathologists that in the skin covering the thorax of lying-in-women, there was occasionally developed a rudimentary mammary gland, apparently *de novo*, and it is to this feature of the subject that Mr. Champneys devotes most of his paper.

It appears from his essay that these adventitious mammary glands are usually situated in the skin of the axilla, which cannot be pinched up freely over them ; on attempting to raise the skin it seems to be tied to the lumps by fibrous septa. They can be raised and isolated from the deeper structures and are not in the situation, nor of the character, nor sensation of glands. The skin over them is usually quite natural in appearance ; they are limited to the hair covered surface ; they are usually soft and somewhat elastic except when swollen; they are commonly somewhat flattened, their vertical diameter being the smallest. They do not possess any nipple, pore nor duct, and in size they vary from the smallest perceptible to that of an egg, or perhaps larger.

Second, as regards their course. They are most commonly noticed on the third or fourth day after delivery, at the time when the breasts fill, but if carefully looked for they can often be found at the time of labor and sometimes the patient is conscious of their presence continuously from her first pregnancy. When once established they sometimes become larger and occasionally painful at the beginning of pregnancy, sometimes at quickening, sometimes even later, but most commonly not until after delivery. Their course during the lying-in usually coincides with that of the breasts, enlarging, becoming tense and perhaps tender about the third day, softening as the breasts soften and becoming smaller or even imperceptible by the end of a fortnight. As a rule, however, their size and tenseness does not coincide with the daily variations of the true breasts in this respect.

Third, as regards their secretion. Of the thirty cases tabulated by

Mr. Champneys, in eleven the mode of obtaining the secretion has not been discovered; in eighteen secretion of some kind was obtained, but in no case did this follow spontaneously as is described in some cases of true supernumerary axillary mammæ. To obtain secretion it was necessary to firmly squeeze the lump between the fingers from the deeper towards the superficial aspect. The secretion was of three principal kinds; granular like the secretion of sebaceous follicles, colostrum and milk; either of these might disappear and reappear within a few days. At the same time various follicles would produce various secretions. The whole lump was not always uniform in its secretions. Sometimes the secretion was expressed from the situation of the sebaceous follicles as marked by the situation of the hairs. Before this secretion was expressed from a follicle for the first time, it was usually seen to swell up, become prominent, whitish in color, and often to discharge a fluid like thin gum, after which other secretions might follow. The whole surface of the lumps produced secretion, there was no centralization.

From the number of cases under Mr. Champneys personal observation, and the corroboration of his statements by several most eminent observers, it would appear that if physicians generally would note the condition of these parts in the lying-in-room they would record much more frequent occurrences of this peculiarity. We prefer rather to record the clinical results in this matter than to go into a study of the peculiar atavistic tendencies thus displayed by the skin in the human race, and we simply suggest to obstetricians generally that they be a little more observant in these respects.

THE MALPRACTICE OF CLAIRVOYANCE.

An important decision concerning the liability of a so-called clairvoyant physician to a suit for malpractice has recently been handed down by the supreme court of Wisconsin.

The plaintiff, a young lad, was taken to a so-called clairvoyant physician to be treated for some hip trouble. The defendant diagnosed the malady as rheumatism by the usual "going into a trance method," and treated (?) it as such. No physical examination was made, the boy continued to grow worse, and yet he was ordered to walk as much as possible. In the complaint it was also stated that the symptoms exhibited by the plaintiff during his illness were such as would lead any physician of ordinary skill and education to diagnose the disease as a well known ailment of the hip joint, and that such a diagnosis having been made, certain well known and established methods of treatment would have been instituted. This the defendant failed to do. The defendant claimed that he was employed by the plaintiff's father to treat his son according to clairvoyant methods and not as a regular physician, and that, notwithstanding the opinions of regular physicians, the patient suffered from rheumatism. All of which was denied by the plaintiff. *The jury rendered a verdict and judgment in the patient's favor.*

It was held by the court that :

1. A clairvoyant physician is liable for failure to exercise the ordinary skill and knowledge of a physician in good standing, practicing in the vicinity, and not merely the ordinary skill and knowledge of clairvoyants. If he holds himself out as a medical expert, and accepts employment as a healer of diseases, but relies for diagnosis and remedies upon some occult influence exerted upon him, or some mental intuition received by him when in an abnormal condition, he takes the risk of the quality of accuracy of such influence or intuition.

2. One who holds himself out as a healer of diseases, and accepts employment as such, must be held to the duty of reasonable skill in the exercise of his vocation ; failing in this, he must be held liable for any damages proximately caused by unskillful treatment of his patient.

3. In an action for malpractice the deposition of the plaintiff's father, taken in a case brought by him against the same defendant, for loss of his son's (the present plaintiff's) services, caused by the same malpractice, is admissible, unless for the purpose of impeaching the father.

4. Counsel's comment, in an action for malpractice, on the failure to call defendant and certain other physicians who were present, as witnesses, if it was improper, could have worked no prejudice when it was promptly counteracted by the judge's disapprobation, and his charge that no presumptions could be drawn from the failure to call such witnesses. It was the court's opinion that :

"The general rule of law is that a physician and surgeon, or one who holds himself out as such, whether duly licensed or not, when he accepts an employment to treat a patient professionally, must exercise such reasonable care and skill in that behalf as is usually possessed and exercised by physicians and surgeons in good standing, of the same system or school of practice, in the vicinity or locality of his practice, having due regard to the advanced state of medical or surgical science at the time.

" The defendant is what is known as a clairvoyant physician, and held himself out, as other physicians do, as competent to treat diseases of the human system. He did not belong to, or practice in accordance with the rules of any existing school of physicians, governed by formulated rules for treating diseases and injuries, to which rules all practitioners of that school are supposed to adhere. The testimony shows that his mode of diagnosis and treatment consisted in voluntarily going into a sort of trance condition, and while in such condition giving a diagnosis of the case, and prescribing for the ailment of the patient thus disclosed. He made no personal examination, applied no tests to discover the malady, and resorted to no other source of information as to the past or present condition of the patient. Indeed he did not profess to have been educated in the science of medicine. He trusted implicitly to the accuracy of his diagnosis thus made, and of his prescription thus given."

A few decisions of this nature would soon render this class of human leeches wary and cautious.

Though nothing, apparently, will stamp them out, yet such judgments would tend to lead them to drop the treatment of disease and confine their peculiar manfestations to telling fortunes and prognosticating the course of true love, etc. While they confine their doings to such nonsense no harm is done, but when they occupy the attention of a patient who suffers from serious organic disease a delay is instituted which is dangerous, let alone the needless suffering experienced. For this reason alone these practices should be stamped out. This decision reflects great credit upon the common sense and wisdom of its promotor.

ENTEROPTOSIS.

The condition known as Enteroptosis was first brought to the notice of the medical profession in 1886 by Glenard, whose name is sometimes applied to it. Since that time numerous writers have recorded themselves as confirming his deductions. M. Glenard has undertaken to show the identity of the symptoms that follow displacement of the abdominal viscera, and particularly of the intestines, with those grouped under the head of neurasthenia ; in short, that enteroptosis and neurasthenia are one and the same thing. The question, briefly considered, may be summarized as follows :

I. Etiology. The female sex is especially liable to enteroptosis, (157 in 200 cases). This predisposition is attributed to the use of corsets. The other leading primary causes are exertion, trauma, parturition, and effort too soon after parturition. Secondarily, enteroptosis may follow various diseases, especially those producing intestinal lesions, as vicious adhesions; such are typhoid fever, dysentery, chronic dyspepsia, bilious lithiasis.

II. Pathological Anatomy and Physiology. The most important and characteristic lesion is a falling of the hepatic flexure of the colon. This section of the colon is badly supported, having no suspensory ligament, while the other portions are well sustained. The pyloro-colic ligament of Glenard attaches the transverse colon to the stomach in the neighborhood of the junction of the left two-thirds of the latter with its right third. The stomach has therefore to support the colon in its middle two-thirds, and the latter may in consequence descend more easily on either side.

Furthermore, at the points where the digestive tube is firmly supported, we find atresia of its canal ; notably at the following orifices : the gastro-duodenal, duodeno-jejunal, the rings of the transverse colon, the sub-pyloric, left subcosto-colic, and sigmoido-rectal. These six openings are pressed upon by the weight of the intermediary coils, which pull upon the ring from either side of the firmly retaining ligaments to the posterior part of the abdomen. The small intestine is maintained by a fibrous fascia, which the superior mesenteric artery follows in passing by the jejunum. If it contains no gas, and if it be depressed, the gas and other materials contained in the duodenum have great difficulty in passing into the jejunum.

The stomach, as has been seen, supports the transverse colon. If the colon be displaced downwards, it pulls upon the stomach, and, when that contracts, opposes its emptying into the duodenum. The stomach consequently is depressed, and we have a gastroptosis. Its long axis becomes vertical, and it is lowered towards the iliac fossa. Atresia of the gastro-duodenal orifice often coexists in consequence of the change of situation, and dilatation of the stomach with atony is produced. Then is established a vicious circle in which gastric dilatation is a cause of entero-stenosis and of enteroptosis, through diminution of solid and gaseous ingesta. This stenosis may extend to the large intestine, which may become as small as the little finger.

The other abdominal viscera may undergo displacement ; such as hepaptosis, (especially in women in consequence of the use of the corset, four to five per cent.) ; nephroptosis (thirty per cent.) ; splenoptosis, (one-half per cent.)

III. Symptoms : Subjective.

1. Asthenic symptoms : Weakness and languor in the region of the stomach and kidneys.

2. Mesogastric symptoms : Sensations of gnawing, dragging, weight, lassitude, false hunger.

3. Gastric symptoms : Flatulence, feelings of suffocation, of oppression, puffing, yawning, then pains, cramps, sensations of burning, vomiting.

4. Symptoms apparently nervous, cerebral or spinal : Insomnia, chills, sweating, irritability, hypochondriasis, melancholia, impotence, cephalalgia, vertigo, ringing in the ears, cough, polyuria, cramps, neuralgias, pains in the regions of the hepatic flexure, simulating bilious colic.

The asthenic and mesogastric symptoms coincide with the following signs :

1. Awakening about two in the morning with false hunger, then malaise and insomnia.

2. Reappearance of the difficulty on rising, or at three in the afternoon.

3. Definite relation between these disturbances and the condition of alimentation ; they increase with the ingestion of fats, acids, wine and milk.

4. Irregularity and insufficiency of the stools ; alternating diarrhœa and constipation. The gastric symptoms comprise also anorexia, with bad tasting foul mouth, coated tongue, flatulence. The most im-

portant symptoms are said to be the intolerance of milk and insomnia.

Objective Symptoms : These are furnished by examination of the abdomen. This is lax, yielding, and soft to palpation, the hypochondriac region is depressed. On deep palpatation one may perceive the colon, the sigmoid flexure and the caecum. The former on account of the narrowness of its calibre, is recognized as a cord, by applying against the anterior face of the vertebral column the radial border of the index finger placed transversely, and by making it glide from above downward, maintaining the pressure. This cord is about 2 centimetres below the umbilicus. In order to find the caecum one directs the ends of the four last fingers on a line corresponding to the angle formed by the vertebral column and the right iliac fossa, pressing deeply, and gliding them on in the same manner. On the left side, the same procedure makes evident the presence of the sigmoid flexure 3 or 4 centimetres above the groin. The existence of these three cord-like bodies is due to entero-stenosis.

As for the stomach, we may find the gastric washing and gurgling described by Prof. Bouchard in dilatation of the stomach.

To detect a movable kidney the following method is used. The examination should be made during a deep inspiration, and comprises three periods. Thus on the left side :

1. The left hand, the thumb being directed forwards, should grasp the soft parts of the side ; the right hand depresses the anterior abdominal walls towards the left thumb. The patient should take a deep inspiration ; if nothing is felt between the fingers, it is because there is no displacement.

2. The displaced organ is seized between the middle finger and the thumb. The thumb is carried as high as possible, and then, when the kidney appears to have reached its lowest limit of excursion at the end of inspiration, it is roughly compressed between the thumb and middle finger, the right hand holding it.

3. Then the left thumb and middle finger are removed, the pressure is gradually lessened, and the kidney is made to ascend by exercising rather severe pressure at the moment when it is about to escape. By this method we may appreciate the amount of its mobility.

Ptosis of the spleen is very rare, and may be recognized by the same method as is used for the kidney.

Examination of the liver also comprises three periods.

1. The physician being on the left side of the patient, brings the border of the liver to the anterior abdominal wall by applying firmly under the right lumbar region the four fingers of the left hand. The region is elevated by these four fingers. The right hand is applied transversely to the right side, and ascends, starting from the groin.

2. The left thumb palpates the various parts of the hypochondriac regions in ascending the right side, from below upwards, and from side to side, to the right costal border. Having reached the limits of the region, it firmly depresses the skin, and examines the deep structures. If the liver is displaced a hard body will be recognized.

3. During a deep inspiration the thumb is made to glide over the border of the liver from behind forwards; it passes over the anterior surface of the organ, and one may thus learn the nature of the depressed mass, the thickness of its anterior border, and its mobility.

Finally, a very important sign is the "girdle test." The physician stands behind his patient, with his arms under the axillae, rests his hands on the sides, and raises the abdomen; the patient immediately feels relief, which ceases when the pressure is removed.

Enteroptosis has a slow, progressive course. In the beginning its symptoms are not well marked; then little by little they become aggravated. Death may supervene from an intercurrent disease, or, in rare cases, from inanition. Patients often remain in a precarious condition up to an advanced age.

IV. Treatment consists of the use of a hypogastric girdle to raise the mass of intestines and increase abdominal tension; also in the regulation of the bowels and the digestion, the use of alkalies, baths, massage, and care about diet. Wine, milk, and indigestible foods are contra-indicated.

Society Proceedings.

BUFFALO PATHOLOGICAL SOCIETY.

REPORTED BY DR. EUGENE A. SMITH, SEC'Y.

The regular meeting of the Society was called to order May 17, 1889, by Dr. Roswell Park. The minutes were approved. A motion to hold no meetings in July and August was made, and lost. The subject for the evening, "Lobar Pneumonia," was then discussed.

Under general discussion Dr. Hopkins reported the following case: A male laborer, 35 years old was taken with fever and delirium, temp. 103, pulse 120. He had no cough, no pain, and physical examination revealed nothing wrong. After forty-eight hours the delirium increased, the abdomen was found retracted and the temperature still remained at 103° and 104°. Pupils were normal. Profuse sweating set in during the next twenty-four hours, the delirium continued and he died. The autopsy revealed meningitis, dry pleurisy and the upper lobes of both lungs hepatized. There was also endocarditis and pericarditis with effusion.

Dr. Stockton said that the intensity of the fever is not always in accordance with the seriousness of the disease, and he cited an illustrative case. In treatment he believes in stimulant liniments to the chest. A valuable stimulant, he believes, when others fail is the inhalation of oxygen, especially when mixed with nitrous oxide (1-5, 4-5 oxygen) to relieve irritation.

Dr. Van Peyma stated that he believes oxygen to act beneficially by lessening delirium.

Dr. Parmenter said that observation of two cases in children leads him to think that delirium indicates a rheumatic diathesis. He spoke of bleeding in a frank, acute case as important, and he also believes in the poultice jacket.

Dr. Rochester said that carbonate of ammonium is of great importance used from the onset as a general stimulant, supplemented by alcohol. It does not disturb the stomach when given in milk. He favors dry cupping and approves of poultices.

Dr. Van Peyma is opposed to the use of carbonate of ammonia in the early stages, but approves of it later.

Dr. Hopkins thinks it important to control the cutaneous circulation. He therefore uses hot foot baths which act as a heart stimulant by increasing the cutaneous circulation and relieving the heart. For a chest jacket he believes the best thing to be carded lambs' wool.

Dr. Park presented a specimen of cancer of the pancreas received from Dr. A. G. Ellinwood, of Attica. The subject was a man of forty-six, who had been in comfortable health previous to his last sickness.

His symptoms were those of pyloric and duodenal disturbance, with paroxysms of pain and vomiting, followed by jaundice. He was seen by Dr. Ellinwood but a few days before death. He had been a saloon keeper and a heavy drinker.

Microscopically the specimen consisted of the upper six inches of the duodenum, and a mass about two and one-half inches in diameter adherent to its left border. This latter was the tumor proper, and seemed to involve, as nearly as could be judged, the head of the pancreas, the ductus communis choledochus, and the hepatic artery with its gastro-duodenal branch. The growth was firm, whitish in color; and had not penetrated into the lumen of either the duct or the vessels.

Dr. Park also reported the surgical details of a young man of thirty-three, who had suffered during the past three weeks from symptoms of intestinal obstruction which were only relieved by cathartic remedies. Of late an abdominal tumor had been discovered, which lay at right angles to the axis of the body, and which, on account of its mobility, had been considered a malignant tumor of the omentum. Abdominal exploration that day had revealed a cancerous degeneration of the entire transverse colon, so much being involved that the abdominal wound was immediately closed without further operative attack. A large degree of interest attached to the case because of the age of the patient and the fact that the mother as well as a brother of nearly the same age had both died of a similar condition of affairs.

Book Reviews.

A CLINICAL ATLAS OF VENEREAL AND SKIN DISEASES. BY ROBT. W. TAYLOR, A. M., M. D. Parts V and VI, Diseases of the Skin. Philadelphia, Lea Brothers & Co. 1889.

ATLAS OF VENEREAL AND SKIN DISEASES. BY PRINCE A. MORROW, A.M.,M.D. Fasciculi X. XI. XII. XIII. New York, Wm. Wood & Co.; Buffalo, J. H. Matteson.

Parts V and VI of Dr. Taylor's superb atlas take up the subjects of pediculosis, erythema and its varieties, tinea versicolor and tonsurans, pityriasis rubra, deumatitis exfoliativa, impetigo, urticaria, pemphigus, tinea barbae and circinata, ecthyma, lupus erythematosus, and herpes zoster.

We everywhere note the same accuracy of description and fidelity of portraiture which have been so conspicuous in the previous parts. In ability to give a good idea of a disease in the briefest manner Dr. Taylor has a few or no superiors. The plates are well executed ; we only regret to see that the source from which many of them are taken is not plainly indicated. The casual observer might imagine that the plates were all original when as a matter of fact most of them are borrowed.

The publishers have perhaps never issued from their long established place a more creditable or striking work than this atlas.

The fasciculi of Dr. Morrow's beautiful series comprise illustrations of the various forms of eczema, impetigo and dermatitis, including dermatitis medicamentosa which is seldom illustrated, herpes in its protaean forms, pemphigus; purpura, psoriasis, lichen ruber and planus, acne, molluscam and verruca. We especially commend the illustrations of herpes zoster, pemphigus foliaceus and pityriasis rubra.

In the text the descriptions of the numerous manifestations of eczema and of drug eruptions are particularly happy. This latter subject is fortunately inserted, since it is both too meagerly handled in other works and because the author had already published a monograph upon it and is consequently peculiarly fitted to treat well of it. The difficult and somewhat obscure subject of lichen is also happily handled and illustrated.

Dr. Morrow's excellent work shows no falling off, either in interest or execution.

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TABLE OF CONTENTS.

ORIGINAL COMMUNICATIONS:

WHEELER, W. A.—Treatment of Small Strictures 1
ELY, WILLIAM S.—Remarks on Typhoid Fever 11
PARK, ROSWELL.—Adenoma of the Male Breast 17

EDITORIAL:

Volume IV 20
The Removal of the Uterus for Cancer 21
The Proper Management of Consumptives in View of the Possible Contagiousness of Tuberculosis 23
Administration of Codliver Oil and Castor Oil in Palatable Forms 25
Why Certain Pills Should Not be Prescribed 27
Opening of the Ogden-Arnot Hospital, at Elmira 28

SOCIETY PROCEEDINGS:

Buffalo Medical and Surgical Association 30
Buffalo Pathological Society 33
Buffalo Board of Health 34

CORRESPONDENCE:

A Visit to Nancy 39

TRANSLATIONS:

The Illness of Emperor Frederick III., Continued 44

BOOK REVIEWS:

.... 49

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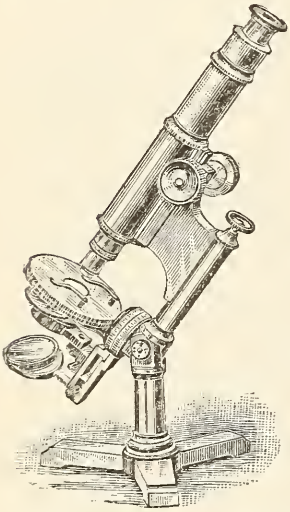

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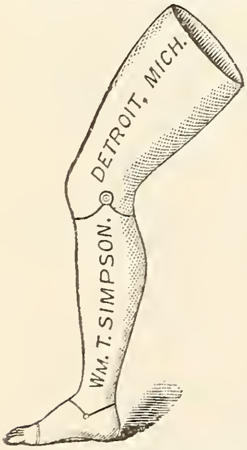
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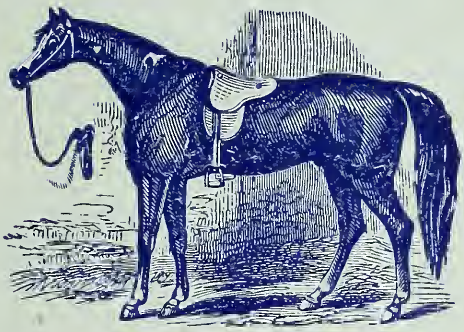

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TABLE OF CONTENTS.

ORIGINAL COMMUNICATIONS:

PARK, ROSWELL.—The Radical Cure of Hernia 55

MOORE, E. M.—The Etiology and Treatment of Certain Fractures of the Upper Extremity 63

FINGER, ERNEST.—Some of the More Recent Anti-Blenorrhagic Remedies .. 70

EDITORIAL:

Surgical Kidney 76

The Administration of the Iodides for Diagnostic Purposes 79

The Operative Treatment of the Hypertrophied Prostate 82

An Interesting Medico-Legal Decision 84

CORRESPONDENCE:

PARMENTER, JOHN.—Letter from London 88

SOCIETY PROCEEDINGS:

Buffalo Medical and Surgical Association 91

Buffalo Pathological Society 93

Erie County Medical Society 96

TRANSLATIONS:

The Illness of Emperor Frederick III., Concluded 99

BOOK REVIEWS:

.... 106

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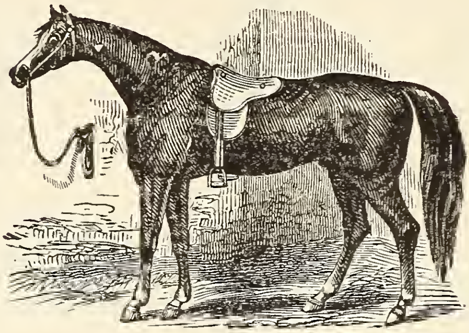

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TABLE OF CONTENTS.

ORIGINAL COMMUNICATIONS:

MOORE, E. M.—The Etiology and Treatment of Certain Fractures of the Upper Extremity, ... 109
ROCHESTER, DeLANCY.—Discussion upon Chronic Alcoholism 116
STOCKTON, CHAS. G.—Discussion upon Chronic Alcoholism 120
HURD, A. W.—Discussion Upon Chronic Alcoholism 122
HOPKINS, H. R.—Discussion upon Chronic Alcoholism 124
PRYOR, J H.—Discussion upon Chronic Alcoholism 126
HOWE, LUCIEN.—The Influence of Flies in the Spread of Egyptian Ophthalmia .. 132
LANG, PROF.—The Use of Gray Oil in the Therapy of Syphilis 137
GRESSWELL, D. ASTLEY.—Therapeutic Value of Oxygen in Scarlet Fever 139
TROWBRIDGE, GRO F.—A Case of Probable Spinal Hemorrhage 143

EDITORIAL:

Uraemia and Alkaloidal Poisoning 144
Prof. John C. Dalton 146

SOCIETY PROCEEDINGS:

Buffalo Pathological Society 149

CORRESPONDENCE:

PARMENTER, JOHN.—Letter from London 151

BOOK REVIEWS:

..... 154

CHAS. HUBBARD, President. J. B. MOORE, Vice-Pres. F. S. HUBBARD, Sec'y and Treas.

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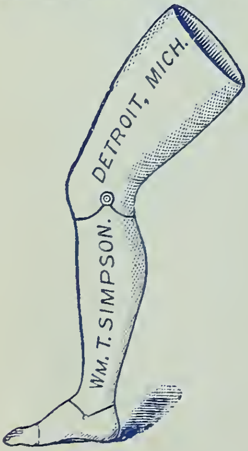
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To the Publishers.

There has of late been more or less talk among the druggists of this city, and especially the members of the Erie County Pharmaceutical Association regarding certain cutting in prices by different ones, and it has been said, perhaps justly, that they mainly originate in the large dry goods and grocery houses. While this may be so, the writer cannot but feel that the druggists are more to blame than the rest, for there is but little doubt, if the matter was properly handled, by prompt, consistent and harmonious action, a satisfactory agreement could be reached. It has been done in other cities. Why not here? But first of all the E. C. P. A. must be sure of harmony in their own ranks. Is it there now, or is there a slight feeling of jealousy among some? In the younger days of this association this matter was taken up and considered in all its bearings and adjusted very amicably indeed. Not only was a friendly feeling created among all but there was a unity of action that counted greatly and was far-reaching. At this time the dry-goods question was brought up, and the fact that such houses sold goods which properly pertained to the druggist, at much less than regular rates, was most thoroughly discussed, and through the work of a committee, created for the purpose, a most pleasing agreement was reached which resulted in the leading dry-goods merchants agreeing not to undersell the druggist in certain articles, the latter purchasing the entire stock of some articles the former had on hand.

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4	Jensen's Crystal Pepsin.......... ...	35
5	Ford's Pepsin in Scales...............	32
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8	Royal Chem. Co.'s Pure Pepsin......	9

"As to the actual strength of these preparations, 1 milligram of the strongest pepsin converted into soluble products 198 milligrams of the pure dry albumen, which would be practically equal to 2000 parts of fluid egg-albumen."

While the use of pepsin was for a time confined chiefly to internal administration, it has been gradually extended to the digestion of visible false membrane and abnormal tissue growths. Thus many physicians have used it with some degree of success in digesting the false membrane of diphtheria and membranous croup This use of pepsin is likely to become much more universal and efficient with the greatly augmented digestive power now possessed by the latest improved pepsin.

In an article entitled "Pepsin in Surgery." by H. B. Douglass, M. D., New York *Medical Record*, Dec. 22d, 1888. the use of pepsin in scales and as an ointment with lanolin as a base in ulcers, was strongly advocated, and several cases illustrating its value in surgical cases cited. Dr. Douglass says: "In all ulcerations covered with a slough, or having a membranous base. pepsin is of use to digest this slough and bring about a healthy condition In cicatricial tissue causing anchylosis. pepsin is of use by dissolving the cellular element. In this condition pepsin may act similarly to mercury and the iodides, or as a digestive.

In operations for increasing the size of the meatus urinarius in which the parts divided tend again to unite, the membrane thus formed may be digested away and the calibre kept intact by the digestive power of pepsin.

We believe that the role of pepsin as a solvent of false membranes will not be its least important one in the future, and would respectfully request reports from physicians who employ it for this purpose, that we may give the facts wide publication to the profession.

To those who wish to learn more of the action and proper method of administration, and incompatibilities of pepsin, and of the interesting history of the researches that have resulted in the superior quality of pepsin now at the disposal of the physician, we shall be pleased to send on request reprints of articles by R. H. Chittenden, Ph D., John R. Winslow, M. D., H. B. Douglass, M D., J. Le Roy Webber, Ph.G, F. A. Thompson, Ph.C., and others: and a sample of Pepsinum Purum in Lamellis for trial.

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TABLE OF CONTENTS.

ORIGINAL COMMUNICATIONS:

HURD, A. W.—Paranoia 157
PHELPS, W. C.—Surgery of the Knee-Joint 163
HAYD, H. E.—Atonic Impotence 173
MOORE, E. M.—A Case of Pistol-Shot Wound 181
PRYOR, J. H.—A Case of Malformation of the Heart 184

EDITORIAL:

The Bacillus of Diphtheria 188
The Present Status of Intubation 192
Commencement of Medical Department, University of Buffalo 193

SOCIETY PROCEEDINGS:

Buffalo Pathological Society 196

BOOK REVIEWS 200

MEDICAL NEWS NOTES 205

PUBLISHER'S DEPARTMENT 206

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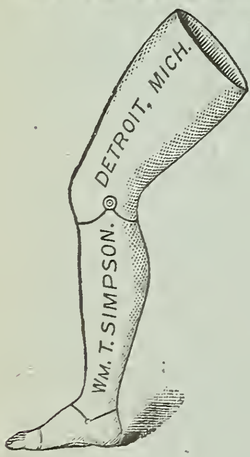
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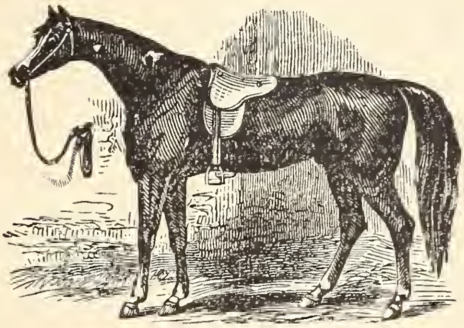

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TABLE OF CONTENTS.

ORIGINAL COMMUNICATIONS:

PETERSON, F.—Electric Cataphoresis as a Therapeutic Agent.................... 207
HOPKINS, H R.—Cardiac Dilatation and Its Treatment.................... 209
EVANS, Z H.—A Case of Laparotomy and Abdominal Drainage for Puerperal Peritonitis.................... 216
SHERMAN, DeWITT H.—A Case of Cæsarian Section.................... 219

CLINICAL LECTURE:

PEPPER, WM—Varicose Aneurism of Arch of Aorta.................... 221

EDITORIAL:

Abdominal Section for Puerperal Peritonitis.................... 224
The Insane in Foreign Countries.................... 225

SOCIETY PROCEEDINGS:

Buffalo Pathological Society.................... 229
CLINICAL NOTE ON SULPHONAL.................... 233

CORRESPONDENCE:

Letter from Philadelphia.................... 234
BOOK REVIEWS.................... 237
CURRENT MEDICAL THOUGHT.................... 242
PUBLISHER'S DEPARTMENT.................... 246

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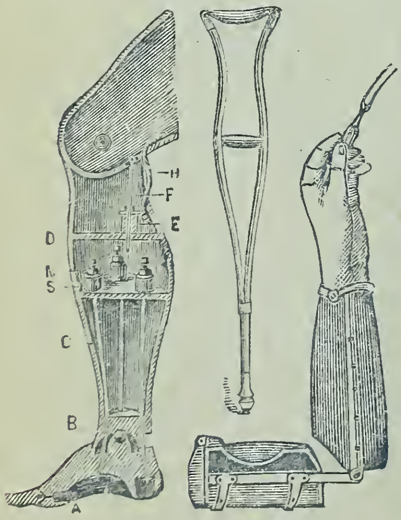

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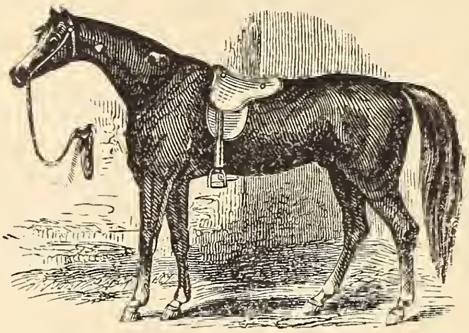

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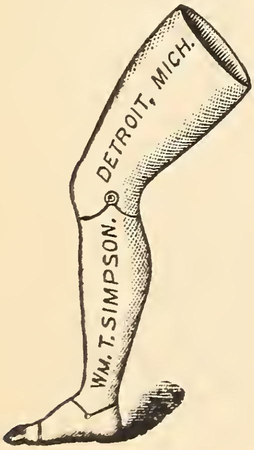

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TABLE OF CONTENTS.

ORIGINAL COMMUNICATIONS:

FORD, W. E.—Electrical Apparatus for Physicians.......... 247
LONG, ELI H.—Functional Albuminuria.......... 250
DAVIS, E. E.—A Case of Brain Abscess.......... 253

CLINICAL LECTURE:

PARK, ROSWELL—A Case of Traumatic Dural Epilepsy with Operation.......... 255
DISCUSSION—Acute Lobar Pneumonia.......... 260

EDITORIAL:

Valedictory.......... 282
Dr. Prudden's Researches on the Etiology of Diphtheria.......... 284
Development of Mammary Functions in the Skin of Lying-In Women.......... 286
The Malpractice of Clairvoyance.......... 288
Enteroptosis.......... 290

SOCIETY PROCEEDINGS:

Buffalo Pathological Society.......... 294

CORRESPONDENCE:

BOOK REVIEWS.......... 296

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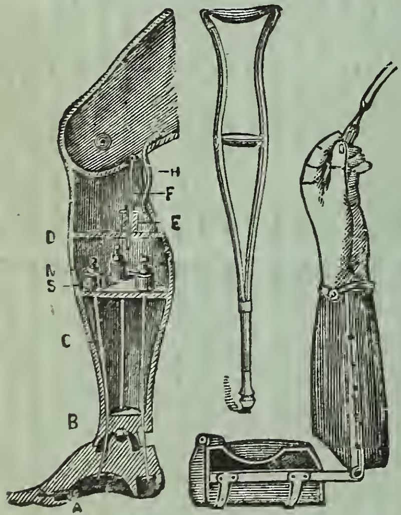

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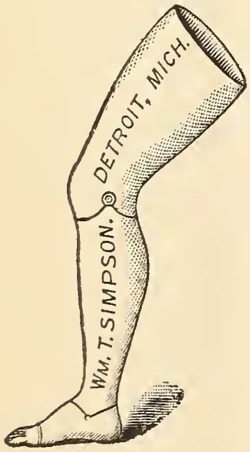
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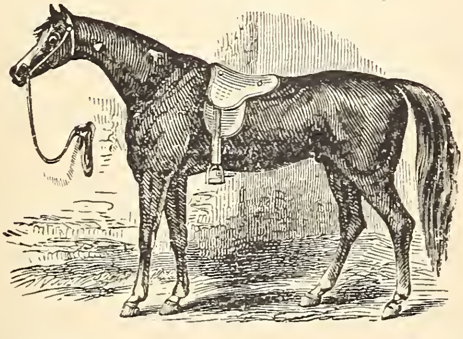

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Statistics show that the mortality rate of infantile diarrhœa, as it manifests itself in the summer months, is higher than that of any other disease.

Unhygienic conditions and improper nourishment, aggravated by high temperature, are the chief causes assigned for the prevalence of this disorder. How to effectually remove or overcome these causes is a question of the gravest importance to sanitarians and physicians. It must be admitted, however, that these conditions, for a large portion of infantile humanity, must continue to exist, and consequently the problem presented to physicians is how to cure the disease in spite of unfavorable conditions when it has firmly established itself. The solution of this question often taxes the ingenuity of the medical attendant in vain.

How shall the conditions present best be met? To answer this query has inspired exhaustive contributions from the pens of our most learned writers. It is admitted by all that one of the causes which incites and perpetuates the gastric and intestinal inflammation is undigested, or partly digested, fermenting milk or other food, the decomposition of which is accompanied by the development of ptomaines and other toxic principles. It is as an aid to the removal of this cause, both in predigesting milk or other food before it is given, and in digesting fermented undigested food in the stomach that Pepsin is indicated in infantile diarrhœa, and its efficacy has been attested by many well known medical writers. See *J. Lewis Smith, M. D. Archives of Pediatrics, Sept.*, '86, *p.* 518; *Nov.*, '86, *p.* 639; *Nov.*, 1864, *p.* 424. *Prof. Vocher, of Berlin Archiv. f. Kinderh. vol.* 9, *p.* 3. *Dr I. N. Love, St. Louis Weekly Medical Review, Aug.*, 88. *T. Lauder Brunton, Diseases of Digestion*, *p.* 291. *A. Holt, N. Y. Archiv. Pediatrics*, 1886, *p.* 732. *A. G. Bigelow, Archiv. Pediatrics*, 1884, *p.* 431. *Discussion at German Medical Congress, at Salzburg*, 1881, *by Demme, Biedert, Gerhardt, Henock, Steffen, Thomas, Soltman, Pfeiffer. Prof. Leeds. Archiv. Ped.*, 1864, *p.* 431, *etc.*

With the improvements that have of late been made in the purity, quality, and digestive efficacy of pepsin, this agent is likely to play a more important and definite part in the treatment of intestinal inflammations than ever before. Its ease of administration, its certainty of action when a proper product is administered, will, we believe, lead to its extensive use.

We say *proper product*, advisedly, for it is well known that many pepsin products are absolutely inert or of very low digestive power, or infested with chemical poisons (leucomaines and ptomaines See Vaughan and Novy's Ptomaines and Leucomaines), the disagreeable odor they possess being significant of putrefaction.

It goes without saying that a product of the latter type would only augment the inflammation, and physicians should look well to the character of the pepsin used. It should, in the first place, be absolutely devoid of the odor characteristic of putrefying mucus, and in the second place, it should freely dissolve in water at all temperatures, for, as solubility is one of the distinguishing peculiarities of the unorganized ferments, it is the best evidence of purity in a pepsin.

We guarantee the purity activity and solubility of our pepsin products. Our pepsin is absolutely free from odor, and has been shown by expert examination to be free from ptomaines and leucomaines, and demonstrated by an exhaustive comparative test to possess twice the digestive power of the most active hitherto introduced. (See Observations on Digestive Ferments, by R. H. Chittenden. Ph. D., *Phila. Medical News*, February 16, 1889.)

In raising the standard of digestive strength by our investigations, we have adopted 1 to 2,000, forty times that required by the last pharmacopœia, believing this strength would best meet practical requirements. We are, however, prepared to supply pepsins of almost any strength up to a product capable of dissolving 6,000 times its weight of albumin.

Since a 1 to 2,000 pepsin has been proven to be amply efficient and most convenient for making the officinal preparations, it is a question if a higher power pepsin, of which an inconveniently small dose would be required, would not unnecessarily embarrass dispensers without accomplishing practically any better results.

It is not probable that the pharmacopœia will ever adopt a standard for pepsin higher than that which we now observe, and it will only be by recognizing this authority that the term "pepsin" can ever come to mean a preparation of definite digestive strength. As it now is, unless some particular brand is specified, a pharmacist is justified in putting up the most worthless products on his prescriptions.

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